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ABSTRACT

This report describes the changes brought about by Project Redirection in New Jersey's Department of Human Services Division of Developmental Disabilities (formerly the Division of Mental Retardation), which now serves not only persons with mental retardation and autistic adults but also those individuals with developmental disabilities. Reports derived from nine task forces developed to examine various programs and administrative issues affected by the division's redirection address the following: intake and eligibility; training; related services; employment; guardianship, advocacy, and self-direction; housing; transportation; recodification; and mental health and developmental disabilities. Each report contains an introduction, an issue statement, recommended actions, and future task force activities. Appendices list members of the advisory committee and the task forces and present additional materials used or developed by the task forces. A glossary of related terms is included. (CB)

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PROJECT REDIRECTION IMPLEMENTATION PLAN: STAGE I

A Project of
The University Affiliated Facility
UMDNJ-Robert Wood Johnson Medical School

in Cooperation with
The New Jersey Developmental Disabilities Council
and
The Division of Developmental Disabilities
New Jersey Department of Human Services

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PREFACE

Implementation Plan: Stage I reflects the cooperative efforts of more than one hundred participants, including individuals with developmental disabilities, parents and guardians, and representatives from public and private agencies providing services to persons with developmental disabilities. The Project Redirection staff extends a hearty thank you to the people who took part in the planning process of Project Redirection and who generously gave their valuable time and expertise to this effort.

All contributors to the work of Project Redirection can take pride in knowing that they played an integral role in the history of the Division of Developmental Disabilities and that by their efforts they helped New Jersey move forward in its pioneering role in the delivery of services to persons with developmental disabilities.

SELECTED ABBREVIATIONS

ARC	Association for Retarded Citizens
BGS	Bureau of Guardianship Services
CABI	Critical Adaptive Behaviors Inventory
COSAC	New Jersey Council of Organizations and Schools for Autistic Children and Adults
DADD	Department of the Public Advocate, Division of Advocacy for the Developmentally Disabled
DDC	Developmental Disabilities Council
DDD	Division of Developmental Disabilities
DHS	Department of Human Services
DMH&H	Division of Mental Health and Hospitals
DMR	Division of Mental Retardation
DPA	Department of the Public Advocate
DVR	Division of Vocational Rehabilitation
FY	Fiscal year (The fiscal year for the state of New Jersey runs from July 1 to June 30. The number after FY indicates the year in which the fiscal year ends. For example, FY1987 refers to the fiscal year that runs from July 1, 1986, to June 30, 1987.)
IHP	Individual Habilitation Plan
JTPA	Job Training Partnership Act
NJAC	New Jersey Administrative Code
PCA	Personal Care Attendant
PIC	Private Industry Council
RFP	Request for Proposal
UAF	University Affiliated Facility
UCP	United Cerebral Palsy

INTRODUCTION

On April 24, 1985, Governor Thomas H. Kean signed legislation that changed the former Division of Mental Retardation (DMR) to the Division of Developmental Disabilities (DDD) and expanded the division's services and programs to individuals with various developmental disabilities.

The bill, S. 1826, was sponsored in the Senate by Senate President Carmen Orechio (D-Essex), and the Assembly version, A. 1841, was sponsored by Assemblyman John Rooney (R-Bergen). The legislation became effective on May 24, 1985. The New Jersey Developmental Disabilities Council was a primary force behind the new legislation and wrote the proposal on which the legislation was based. In addition to the New Jersey Developmental Disabilities Council, other supporters of the legislation included the New Jersey Department of Human Services, the New Jersey Department of the Public Advocate, the Association for Retarded Citizens/New Jersey, the United Cerebral Palsy Associations of New Jersey, the Epilepsy Foundation of New Jersey, the New Jersey Council of Organizations and Schools for Autistic Children and Adults, the Association of the Deaf and Blind, Spectrum for Living, the Matheny School, and the Spina Bifida Association of New Jersey.

The Division of Mental Retardation served only persons with mental retardation and autistic adults. These persons will continue to receive services under the Division of Developmental Disabilities. However, according to the council's estimates, approximately 2,300 additional persons will be eligible for services under the new division.

The new programs of the Division of Developmental Disabilities are being planned and phased in over a three-year period. Among the programs that will be available to eligible persons will be respite care, homemaker services, case management services, and supportive work programs. The projected cost of implementing these programs over a five-year period is \$9.5 million.

The Developmental Disabilities Council awarded a grant to the University Affiliated Facility (UAF) at the University of Medicine and Dentistry of New Jersey—Robert Wood Johnson Medical School to devise an implementation plan for the new division, and Project Redirection was formed to carry out this responsibility.

Between April and June 1985, Catherine Rowan, Executive Director of the Developmental Disabilities Council; Eddie C. Moore, Director of the Division of Developmental Disabilities; and Kathleen Miller, Project Redirection Coordinator from the University Affiliated Facility, conducted six orientations to Project Redirection for over 275 staff members of the central and regional offices of DDD. On April 30, the UAF sponsored a Project Redirection planning session. John O'Brien, Ph.D., led the session held for the benefit of the administrative staff of DDD.

A Project Redirection Advisory Committee was appointed by Catherine Rowan and Eddie C. Moore. This advisory committee consisted of 28 members, including persons with developmental disabilities, parents and guardians, and representatives from state and private agencies. This committee was charged with advising and making recommendations to the division director as the necessary plans and programs were developed to ensure the provision of services by DDD to all eligible developmentally disabled persons. (See Appendix I, Introduction, for list of committee members.) The advisory committee met on May 21 and approved a Planning Matrix/Time Table and nine task forces.

These nine task forces examined various program and administrative issues affected by the division's redirection. The task forces and their charges are listed below. (See Appendix II, Introduction, for names of all task force participants.)

Task Force Charges

1. The **Intake/Eligibility Task Force** was charged with developing over a three-year period a plan to provide individualized services to a broad range of eligible persons with developmental disabilities, regardless of the presence of the diagnosis of mental retardation, and with operationalizing the definition of developmental disabilities as mandated by S. 1826—a necessary first step in the planning process so that DDD can proceed with the establishment of an appropriate service system to meet the individual needs of its broadened client population. To realize this goal the Intake/Eligibility Task Force set out to develop a mechanism for determining an applicant's eligibility for DDD services.
2. The **Training Task Force** was charged with designing a system for the delivery of training programs on developmental disabilities to a variety of targeted audiences including division staff, providers, parents, and professionals. Its recommendations are to be used as a basic guideline and appropriately adjusted upon implementation.
3. The **Related Services Task Force** was charged with surveying the related services needs of non-mentally-retarded, developmentally disabled persons, e.g., homemaker services and respite care. The task force will identify existing services and make recommendations for service utilization and program development to the Project Redirection Advisory Committee.
4. The **Employment Task Force** was charged with examining the employment needs of non-mentally-retarded, developmentally disabled individuals and with examining existing in- and out-of-state work programs—with an emphasis on interfacing with private industry. The task force will report to the Project Redirection Advisory Committee its findings on ways in which to strengthen existing employment opportunities for non-mentally-retarded, developmentally disabled persons and will recommend alternative models.
5. The **Guardianship/Advocacy/Self-Direction Task Force** was charged with looking at the potential consumer population in relation to self-direction issues (fostering self-direction and participation in decision-making), developing strategies to support clients in these areas, and examining the current guardianship legislation, policies, and practices in relation to mentally retarded persons and the newly eligible non-mentally-retarded, developmentally disabled population. The task force will develop all changes and modifications needed in guardianship policies and practices and recommend these changes and modifications to the Project Redirection Advisory Committee. The task force was also charged with reviewing the effectiveness of advocates and advocacy systems for developmentally disabled persons and formulating recommendations for enhancing and broadening their impact.
6. The **Housing Task Force** was charged explicitly with the responsibility for researching the housing needs of non-mentally-retarded, developmentally disabled individuals and with making recommendations for developing appropriate housing for this group. Implicit in the task force charge was the expectation that DDD will continue to develop community-based housing for its mentally retarded clients, as detailed in the DDD planning documents: *Phase Two* and *The Equity Plan*.
7. The **Transportation Task Force** was charged with studying the transportation needs of non-mentally-retarded, developmentally disabled individuals, the existing resources that might meet those needs, and the current gaps in transportation services for disabled persons.
8. The **Recodification Task Force** was charged with analyzing the impact of the Developmental Disabilities Act (S. 1826) on existing statutes, administrative codes, division circulars, policies, and procedures. The task force will recommend the necessary changes in all statutory and administrative materials to the Project Redirection Advisory Committee.
9. The **Mental Health/Developmental Disabilities Task Force** was charged with evaluating the access to community mental health programs that is currently available to individuals

with developmental disabilities. The survey of service needs completed by the Mental Health/Developmental Disabilities Task Force will be used in the assessment of community programs. The task force will recommend strategies for service use and joint program development to the Project Redirection Advisory Committee.

The task forces were assigned reporting dates for preliminary recommendations based on their priorities within the implementation process. By the end of July 1985, all task forces had met and had devised their individual work plans. Between August 26, 1985, and January 6, 1986, the task force chairpersons met monthly, and each task force presented preliminary recommendations to the advisory committee and the DDD executive staff. Project Redirection issued two written interim reports reflecting the task forces' preliminary recommendations (one report on October 31, 1985, and the other on January 6, 1986).

On October 24, 1985, the Developmental Disabilities Council members were briefed on the most recent and upcoming phases of Project Redirection.

The UAF sponsored a three-day training session, October 28-30, 1985, for DDD staff members in community education. This training session at the Robert Wood Johnson Medical School began with a discourse on the legislation that brought Project Redirection into effect. The remainder of the session was conducted by experts in the field and consisted of lectures and discussions about several specific developmental disabilities.

Between December 17, 1985, and April 17, 1986, the task force chairpersons continued to meet monthly, and each task force presented its final recommendations to the advisory committee and the DDD executive staff. In addition to its interim and final recommendations, the Intake/Eligibility Task Force issued a progress report on its work to the advisory committee on December 17, 1985, and to the executive staff on January 16, 1986.

A major accomplishment during the first year of Project Redirection was the Intake/Eligibility Task Force's successful development of the Critical Adaptive Behaviors Inventory (CABI) to assess, according to New Jersey's new functional definition of developmental disabilities, adult applicants' eligibility for DDD services. The development of CABI was necessary because New Jersey was the first state to adopt and begin implementing the federal functional definition of developmental disabilities. The completion of two pilot studies—an interim pilot and a southern regional pilot—is essential to the implementation of this uniform statewide intake system for adult applicants to DDD. The interim pilot was held March 3-21, 1986. It tested the validity of CABI and provided hands-on training experience in the administration of CABI for those DDD intake workers participating in the pilot. No determinations of eligibility for DDD services were made at that time.

To prepare for the interim pilot, DDD intake personnel attended a two-day training program that gave them an overview of developmental disabilities. This program took place on February 5-6, 1986. In addition, all participants who were to administer CABI (provider agency and DDD staffs) during the interim pilot attended a one-day training session on the administration of CABI. This session occurred on February 28, 1986. Finally, a three-hour feedback session was held on April 11, 1986, to gather impressions from all pilot participants.

The southern regional pilot will test the feasibility of the new intake system in a regional office. This pilot is scheduled to begin in early July 1986 and will run for a two-month period. The proposed intake process will be used with a sample number of individuals who are currently on the division's registry and awaiting eligibility determination. These applicants will have their eligibility status determined during the pilot.

The Intake/Eligibility Task Force efforts laid the groundwork needed for the implementation of the recommendations of the other eight task forces. The following nine task force reports provide an inclusive implementation plan for DDD and reflect the considerable amount of work done by all participants during the first year of Project Redirection. Plans for the remaining two years of the transition process can be found in the chapter following the task force reports—Project Redirection: Stage II.

INTAKE/ELIGIBILITY TASK FORCE

Task Force Charge

Senate Bill 1826 charged the Division of Developmental Disabilities (DDD) with developing over a three-year period a plan to provide individualized services to a broad range of eligible persons with developmental disabilities, regardless of the presence of the diagnosis of mental retardation. The Intake/Eligibility Task Force was charged with operationalizing the definition of developmental disabilities as mandated by S. 1826—a necessary first step in the planning process so that DDD can proceed with the establishment of an appropriate service system to meet the individual needs of its broadened client population. To realize this goal the Intake/Eligibility Task Force set out to develop a mechanism for determining an applicant's eligibility for DDD services.

Introduction: New Jersey's Adopted Definition of a Developmental Disability

The legislatively mandated definition of developmental disabilities in S. 1826 is the foundation for determining which individuals are eligible for services. The definition reads as follows:

"Developmental disability" means a severe, chronic disability of a person which: (1) is attributable to a mental or physical impairment or a combination of mental or physical impairments; (2) is manifest before age 22; (3) is likely to continue indefinitely; (4) results in substantial functional limitations in three or more of the following areas of major life activity, that is, self-care, receptive and expressive language, learning, mobility, self-direction and capacity for independent living or economic self-sufficiency; and (5) reflects the need for a combination and sequence of special interdisciplinary or generic care, treatment or other services which are of life-long or extended duration and are individually planned and coordinated. Developmental disability includes but is not limited to severe disabilities attributable to mental retardation, autism, cerebral palsy, epilepsy, spina bifida and other neurological impairments where the above criteria are met.

The adoption of this definition of a developmental disability shifts the means for determining service eligibility from one based on the presence of a categorical diagnosis of a disability or disease classification to one based on the functional assessment of the real-life limitations resulting from an individual's physical and/or mental impairments (criteria 1 and 4).

The verification of an applicant's meeting criteria 2 and 3 is also a legislatively mandated component of the eligibility determination. Criterion 3 requires that an individual's disability "is likely to continue indefinitely," so it must be determined that the disability is chronic. Criterion 2 states that "a person's disability must be manifest before age 22." Therefore, the age of the individual at the onset of his/her disability must also be determined in the eligibility determination process. However, an important exception clause for this age-22 restriction is in the legislation (section 9): "Within the limits of available funding and services, the director may declare as eligible for services under this act individuals who meet the criteria for developmental disability pursuant to subsection b. of section 3 of this act except that their disability was manifested after the age of 22 but before the age of 55." Consequently, if funds and services are available, a DDD director may make exceptions to the rule that the onset of client's disability must be manifest before he/she is age 22.

Criterion 5 states that the applicant must have a "need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of life-long or

extended duration and are individually planned and coordinated." The intent of the legislation is to include in the eligibility determination process the verification of an individual's need for ongoing, coordinated services that will assist him/her in living in the least restrictive environment and as independently as possible. This intent charges DDD to primarily broker in a coordinated fashion the existing service system for a client in order to meet his/her individual needs. The development and provision of necessary support services where none exist are essential components of an ongoing planning effort and must be addressed by DDD in order to meet the diverse needs of people with a variety of developmental disabilities.

To ensure the continued provision of services to DDD's previously mandated client population, individuals with mental retardation, the following clause was adopted as part of S. 1826 (section 8): "Notwithstanding any provisions of this act to the contrary, the eligibility of mentally retarded persons for services of the division shall continue as provided in chapter 4 of Title 30 of the Revised Statutes." The updated definition of mental retardation in S. 1826 states: "'Mental retardation' shall mean a state of . . . significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period." In the unlikely event that an individual with mental retardation is not determined eligible under the new intake process based on the newly adopted functional definition of a developmental disability, eligibility can be determined on the basis of a diagnosis of mental retardation as defined above.

Operationalizing New Jersey's Definition of a Developmental Disability

Criterion 4 ("results in substantial functional limitations in three or more of the following areas of major life activity, that is, self care, receptive and expressive language, learning, mobility, self-direction and capacity for independent living or economic self-sufficiency") mandates that eligibility for DDD services is in part dependent upon the functional assessment of the real life limitations resulting from the applicant's physical and/or mental impairments. Therefore, an accurate assessment of the applicant's current functional abilities is needed to determine eligibility for services.

After a lengthy national search and review of existing assessment tools, the task force concluded that there was no one assessment instrument available to meet DDD's need to verify criterion 4 of the eligibility determination process. But through the initial efforts and assistance of an interdisciplinary team of professionals from the Matheny School in collaboration with the Intake/Eligibility Task Force, a rough draft of an eligibility assessment instrument was conceptualized. Paul J. Zumoff, Ph.D., a member of the original team, was subsequently secured as lead designer for an eligibility assessment tool and as consultant to the Intake/Eligibility Task Force. This chain of events led to the development of the existing tool, the Critical Adaptive Behaviors Inventory (CABI). (See Appendix I, Intake/Eligibility.)

CABI is designed specifically to facilitate the screening of an adult applicant to DDD by assessing his/her functioning in the six areas of major life activity specified in DDD's legislation. CABI assesses only behaviors that are critical for independent adaptation to the ordinary demands of adult life.

A variety of ability statements are presented within each major life activity. Each statement describes a critical ability and, where appropriate, the component skills that comprise the ability. In some instances, examples are offered to clarify various aspects of the statement. Some ability statements assess primarily physical abilities; some, mental abilities; others, a combination of physical and mental abilities. Space for short comments follows each statement so that the intake worker can record the specific strengths and weaknesses of an applicant's performance.

Each ability statement is presented as a positive, i.e., it describes a critical ability rather than a deficiency. The intake worker's task is to assess whether the applicant possesses the ability as stated (scored "Yes") or does not possess that ability (scored "No"). If the intake worker is not able to reach a "Yes" or "No" conclusion, provision is made for recording the no-conclusion response (scored "?").

CABI records information from four sources for each ability statement: (1) direct observation by the intake worker (OBSERVATION); (2) available documents such as psychological reports, medical reports, allied health specialty evaluations and school records (DOCUMENTS); (3) self-report by the applicant (APPLICANT); (4) verbal reports by members of the applicant's family, personal care assistants or other reliable individuals (INFORMANT).

With the development of CABI and the continuing refinement of the instrument, the task force anticipates that it has met the the most challenging component of operationalizing New Jersey's definition of a developmental disability for service eligibility.

The following section outlines the administrative procedures for verifying within the regional office the additional four criteria in the developmental disability definition.

Recommended Intake Process

In the design of the intake procedures and process, the Intake/ Eligibility Task Force carefully considered existing resources and practices and based its decisions on the following premises:

1. Eligibility determinations should be made as quickly as possible.
2. All applicants, including those with a diagnosis of mental retardation, should go through the same eligibility determination process.
3. The intake unit should be responsible for eligibility determinations only. After eligibility is established, the case should go to the appropriate unit.
4. The provision of crisis intervention services to individuals not yet determined eligible should be transferred out of the intake unit to the appropriate service delivery unit.
5. Based on the results of CABI, specifically in the areas of learning and self-direction, the intake worker can refer applicants to the psychologist to initiate determination of need for guardianship services.
6. In the majority of cases, the intake worker (under the supervision of the intake unit supervisor) can independently determine eligibility by using CABI and verifying the other four criteria.
7. When eligibility is questioned, the review of an individual's eligibility status by a service assessment team is essential to the intake unit for support, professional consultation and assistance in the decision-making process, and for the provision of an equitable and informed eligibility determination for the applicant.
8. The establishment of a service assessment team will support the intake worker and form a bridge between the intake process and case management. This interdisciplinary team will provide a comprehensive further evaluation of all questions regarding eligibility. It will also provide an evaluation of and prescription for services for clients who are determined eligible but for whom service requirements are not apparent. Members of the service assessment team should not be responsible for the provision of direct services.
9. This evaluation and planning team will include the following:
 - Learning disabilities teacher-consultant
 - Nurse
 - Occupational therapist
 - Personal care attendant
 - Physical therapist
 - Physician
 - Psychologist
 - Recreation specialist
 - Rehabilitation engineer

Social worker
Speech and language therapist

The needs of each case will determine which of the above specialists should be consulted.

10. Other speciality consultation will be arranged as needed.
11. The service assessment team must be made available on a regional basis.
12. The establishment of a service assessment team to work in concert with the existing DDD staff is essential. New clientele may not be as clearly defined in terms of eligibility or service need as previous clients.
13. There are existing services that DDD staff can utilize for newly established clients, e.g., the case management service already established within DDD may fill the primary service need. However, there are also service deficits. The service assessment team will assist the DDD staff in compiling information on aggregate client program needs and making recommendations for program development.
14. In the event of a determination of ineligibility by the intake unit, an applicant's status must be reviewed by the service assessment team. In all cases, ineligibility must be verified by the service assessment team.

Proposed Intake Process Based on the Preceding Premises

1. Initial Application Process

A. Applicant appears not to be eligible.

- (1) Person calls regional office and requests information about DDD.
- (2) Intake worker, using the request for service form, gathers initial information. (See Appendix II, Intake/Eligibility.)
- (3) On the basis of the initial information, applicant does not appear to meet the eligibility criteria.
- (4) Person is referred to an appropriate service.
- (5) Referral is noted on request for service form; form is filed; on a weekly basis the intake supervisor reviews all referrals for appropriateness.
- (6) As soon as possible but no later than three working days after the initial conversation, a package is sent to the caller to confirm the telephone conversation. Included in the package is confirmation letter B, DDD brochure, Community Services brochure, and factsheets on intake, appeal, and guardianship processes. (See Appendix III, Intake/Eligibility.)
- (7) Process is complete unless the applicant initiates further action.

B. Applicant appears to be eligible but existing services outside DDD can fill his/her needs.

- (1) Person calls regional office and requests information about DDD.
- (2) Intake worker, using the request for service form, gathers initial information. (See Appendix II, Intake/Eligibility.)
- (3) On the basis of the initial information, applicant is a candidate for eligibility or requires a service already existing outside DDD.
- (4) Intake worker refers caller to the appropriate service.

- (5) Caller is informed that pursuit of eligibility for DDD service is still an option.
- (6) Caller makes decision to continue with eligibility determination or to end process.
- (7) If caller chooses to end the process, initial application process A follow-up procedures (steps 6 and 7) are carried out. If caller decides to continue with eligibility determination, initial application process C follow-up procedures (steps 3-9) are used.

C. Applicant appears to be a candidate for eligibility.

- (1) Person calls regional office and requests information about DDD; he/she is referred to the intake worker screening calls.
- (2) Intake worker, using the request for service form, gathers initial information. (See Appendix II, Intake/Eligibility.)
- (3) On the basis of the initial information, applicant appears to be a candidate for eligibility.
- (4) The interviewing intake worker informs the caller of the name, telephone number, and office hours of the assigned intake worker who is designated on the basis of the unit's method for case assignment.
- (5) As soon as possible but no later than five days after the initial screening call, the assigned intake worker contacts the caller to arrange an appointment for an in-person interview.
- (6) When possible, an appointment is scheduled within fifteen calendar days.
- (7) Package is sent to the applicant as soon as possible but no later than three working days after the interview date, place, and time have been arranged. This package includes confirmation letter A, DDD and Community Service brochures, and information on DDD with factsheets for the intake, appeal, and guardianship processes. (See Appendix IV, Intake/Eligibility.)
- (8) Existing reports relative to the individual's functional limitations are requested from the applicant. (See Appendix V, Intake/Eligibility.)
- (9) If applicant is identified as mentally retarded, the intake worker requests (for community care waiver purposes) a psychological evaluation with an IQ score, to verify that the applicant was mentally retarded before age eighteen.
- (10) Process moves on to eligibility assessment.

2. Eligibility Assessment

- (1) The in-person interview is held with the applicant or, if necessary, the applicant and informant.
- (2) Information about DDD services is given to the applicant, and the assessment for services procedures of the intake process are fully outlined for him/her.
- (3) The applicant signs the application form (DDD-1). (See Appendix VI, Intake/Eligibility.) Forms for consent to release information are obtained.
- (4) Information on the current living situation is obtained during the interview and reported on the client information form. (See Appendix VII, Intake/Eligibility.)
- (5) CABI is administered to the applicant by the intake worker. (See Appendix I, Intake/Eligibility.)
- (6) If necessary, further documentation from the applicant is requested at this time.
- (7) The intake worker tells the applicant the next step in the process and the corresponding timeline.

- (8) If reports are not received within thirty days, a tickler system issues a second request for this information. If additional reports are needed for the eligibility process, they are also requested by means of this system. (The tickler system should be maintained by a clerical staff.)

3. Eligibility Outcomes

A. Applicant meets the eligibility criteria.

- (1) Based on a review of CABI and necessary documentation from other sources and the verification that the applicant meets the other four criteria, the intake worker completes the social history and eligibility checklist. (See Appendixes VIII and IX, Intake/Eligibility.)
- (2) The intake worker recommends the applicant for eligibility.
- (3) The applicant is informed of his/her eligibility status based on the intake supervisor's review of the completed application forms. The DDD-2 is completed and mailed to the applicant within three working days. The applicant is asked to return the form to the regional office within fifteen calendar days. (See Appendix X, Intake/Eligibility.)
- (4) If the applicant's disability is determined to be mental retardation, the intake worker and psychologist meet to determine eligibility for ICF-MR in accordance with the community care waiver and completed DDD-CCW-1. (See Appendix XI, Intake/Eligibility.)
- (5) Copies of the request for service and client information forms are forwarded to the regional database manager who includes the information from these forms in a casebook prepared for the case management staff.
- (6) From this point on, responsibility for coordination of the client's services is transferred from the intake worker to the assigned case manager.

B. Applicant's eligibility status is uncertain.

- (1) The in-person interview has occurred. The intake worker has reviewed CABI and all other relevant documentation and has completed the client's social history. (See Appendix IX, Intake/Eligibility.) Based on this information, the applicant's eligibility is uncertain.
- (2) After the intake unit personnel's consultation with the service assessment team, the applicant is further assessed for eligibility.
- (3) If he/she is ineligible, eligibility outcome C procedures are followed.
- (4) If the applicant is eligible, eligibility outcome A procedures are followed.

C. Applicant does not meet eligibility criteria.

- (1) Intake worker has determined on the basis of a review of the in-person interview information (CABI results) and the completion of the client's eligibility checklist and social history, that applicant does not meet the eligibility criteria.
- (2) The service assessment team reviews appropriateness of ineligibility decision.
- (3) Applicant is informed in writing of the decision and his/her right to a formal appeal. This information is sent as soon as possible but no later than five working days after determination of ineligibility is made.

Steps Necessary for the Successful Implementation of the Proposed Intake System

Two pilot studies, the interim pilot and the southern regional pilot, must be completed to realize the goal of implementing a uniform statewide intake system for adult applicants to DDD. Due to the action-oriented posture of the Intake/Eligibility Task Force, much of the interim pilot has been completed, and groundwork has been prepared for the southern regional pilot.

Interim Pilot

The interim pilot tested the validity of CABI and provided hands-on training experience in the administration of CABI for those DDD intake workers participating in the pilot. No determinations of eligibility for DDD services were made at this time.

The DDD southern regional office intake unit was selected to participate in the pilot. Also selected were eight provider agencies that serve individuals with developmental disabilities: The United Cerebral Palsy Association of Monmouth-Ocean Counties; Epilepsy Foundation of New Jersey; Mercer County Office on the Handicapped; Burlington County Occupational Training Center; Matheny School; Princeton Child Development Institute; Atlantic County Opportunity Center; and Bancroft Community.

Volunteers who were receiving services from the participating agencies and who had a wide range of developmental disabilities participated in the interim pilot. They were administered CABI twice—once by a DDD intake worker and once by a designated participating agency professional.

To prepare for the interim pilot, DDD intake personnel attended a two-day training program that gave them an overview of developmental disabilities. This program took place on February 5-6, 1986. In addition, all participants who were to administer CABI (provider agency and DDD staffs) attended a one-day training session on the administration of CABI. This session occurred on February 28, 1986.

The interim pilot was held during the three-week period from March 3 to 21, 1986. Thirty-five volunteers were administered CABI twice, once by a participant agency professional and once by a DDD intake worker. Each professional was instructed to use the pilot feedback form to comment on the administration of CABI. (See Appendix XIII, Intake/Eligibility.) Additional impressions were gathered from all pilot participants during a three-hour feedback session held April 11, 1986. The session was sponsored by Project Redirection.

The analysis of data from the interim pilot included CABI, feedback forms, and the information from the April 11 feedback session. Finally, CABI was revised, based on results of the interim pilot. During the southern regional pilot, this revised CABI will serve as the functional assessment instrument for verifying criterion 4 of the definition of a developmental disability. (See Appendix XIV, Intake/Eligibility.)

Southern Regional Pilot

The southern regional pilot will test the feasibility of the new intake system within the context of a regional office. As mentioned above, a revision of CABI based on the interim pilot will be used in this pilot to verify criterion 4. In addition, the intent of this pilot will be extended to include testing all components of the proposed intake process and verifying all eligibility criteria and necessary administrative procedures.

For a two-month period, the pilot as conceptualized will use the proposed intake process with a sample number of individuals who are currently on the southern region's developmental disabilities registry and awaiting eligibility determination. These applicants will have their eligibility status determined at this time.

The Intake/Eligibility Task Force recommends the accomplishment of certain actions prior to the implementation of the southern regional pilot. These actions are scheduled to be completed by June 30, 1986. The task force in an exemplary manner agreed to take primary responsibility for accomplishing these tasks and will work with the identified necessary complementary component(s) of DDD and/or the UAF.

Recommended Action

1. Refine the pilot design and methodology for the selection of a sample size.
2. Review all proposed intake forms for their efficiency and appropriateness.
3. Incorporate the community care waiver eligibility process into the proposed intake process.
4. Complete and/or secure all relevant information materials pertaining to the applicant. This material should include the intake/appeal process fact sheet, DDD brochure, guardianship brochure, and Community Services brochure.
5. Develop a mechanism to secure a service assessment team that will be available during the southern regional pilot.
6. Review and clarify all necessary administrative intake procedures.
7. Provide additional training for the southern regional office intake staff on all components of the intake process. (Training to be provided by the UAF.)
8. Revise necessary legal forms DMR A-1 and DMR A-3.
9. Provide training for case management and program support unit staffs. (A two-day course providing an overview of developmental disabilities was presented by the UAF, June 16-17, 1986.)

Statewide Implementation of the Proposed Intake System

Within six weeks of the completion of the southern regional pilot, the core requirements for implementing the proposed intake system on a statewide basis are expected to be in place. They will be based on the analysis of the southern regional pilot and will include the following:

1. Final revision of CABI
2. Final format for verifying the additional four criteria defining a developmental disability
3. Refined intake process including all necessary forms and timelines for completion of the various steps within the eligibility determination process
4. Recommendations for adequate staff/client ratios

The ongoing Intake/Eligibility Task Force will take lead responsibility for coordinating with the appropriate divisional component to accomplish the preceding requirements. Before the statewide implementation of the proposed intake system, this task force also recommends fulfillment of the objectives listed below.

Recommended Objectives

1. Training of all relevant personnel completed prior to the statewide initiation of the proposed intake system. The Intake/Eligibility Task Force conducted a training needs assessment of all intake unit personnel in August 1985. (A summary of the results of this survey can be found in Appendix XV, Intake/Eligibility.) Therefore, it is recommended that the results

of this survey form a basis for the topics to be addressed in training intake unit personnel. The task force also recommends the development of a plan to train all relevant divisional staff in the new intake procedures and to provide them with an overview of developmental disabilities. This should be done in conjunction with the UAF.

2. Coordination of the new intake forms with existing and newly developing computer systems must occur prior to the statewide implementation of the proposed intake system. This includes coordination with the Project Case Book and the Academic Center on Developmental Disabilities to ensure streamlined data collection and to avoid duplication of effort.
3. The DDD circular on eligibility should be finalized prior to statewide implementation to ensure the availability of guidelines to applicants and staff.
4. An examination of the procedure for redetermination of eligibility should be made to ensure easy exit from the system. The task force recommends the interdisciplinary team responsible for developing a client's program as the responsible party for making redetermination decisions. The process should include an appeal procedure for the benefit of an individual client.
5. Prior to statewide implementation, the appeal process for eligibility determination should be reviewed to ascertain if any changes are necessary due to the new intake process.
6. The Intake/Eligibility Task Force encourages continued negotiations between DDD and the Division of Mental Health and Hospitals to ensure that the appropriate agency and the appropriate services are available to persons with developmental disabilities and to those with mental health needs. Clear mechanisms for case mediation should be made available to direct service staff on a local level to ensure appropriate client services and to prevent interdivisional conflict.
7. The Intake/Eligibility Task Force endorses the creation of a group to work on an intake/eligibility process for children. This group will focus on operationalizing the eligibility criteria for children and will base its work on the principles and foundational work involved in determining the eligibility process for adults.

Future of the Intake/Eligibility Task Force

Due to the complexity of the task and the action-oriented position taken by the Intake/Eligibility Task Force during Stage I of Project Redirection, the task force recommends that this work group continue. It will serve as the formal body overseeing the implementation of the new intake process and will continue to recommend policy to the DDD director for adoption by DDD.

The chairperson should be a knowledgeable DDD staff person who has been involved in the existing group's work. He/she will automatically become a member of the primary steering committee. The Project Redirection Coordinator will ask current members to remain on the committee and when necessary, will select replacements from DDD and the private sector.

TRAINING TASK FORCE

Task Force Charge

To design a system for the delivery of training programs on developmental disabilities to a variety of targeted audiences including division staff, providers, parents, and professionals.

The recommendations are to be used as a basic guideline and appropriately adjusted upon implementation.

Introduction

The following report outlines the training resources available to the Division of Developmental Disabilities (DDD), an organizational structure for the delivery of programs, specific work responsibilities assigned to training personnel, and preliminary cost factors. (See Appendixes I and II, Training.)

More importantly, the report provides DDD with a central and regional system for the development and implementation of training programs for staff, providers, and constituent groups. The Training Task Force recognizes that the other task force committees assigned to Project Redirection are making recommendations involving training and that these recommendations need to be integrated into the total plan. The delivery system outlined in this report provides the vehicle for this integration so that a well-defined, consistent training program can be implemented throughout the state.

Issue Statement: Training

Currently, DDD has seven individuals on staff who primarily deliver home training programs for contracted providers. These providers, as well as division staff, will need specific training relative to the needs of this new developmentally disabled population.

Statement of Need

A review of the literature points out that the most effective way to train staff is through the design of minimum standards, whereby measurable goals and objectives can be established to ensure accountability and thus ensure good client programming. If this goal is to be achieved, an organizational system with additional staffing must be in place.

Recommended Action (listed in order of priority)

1. The DDD director should approve the creation of regional training units with a statewide total of four principal community program specialists (reporting to the regional administrator), five senior community program specialists, and four senior clerk transcribers. These training units will be responsible for the implementation, monitoring, and record-keeping of all training functions within the region. The existing training staff will be part of these units. (See recommended action under Training Source: Regional Training Unit Supervisor.)

2. The DDD director should approve the allocation of funds to purchase training equipment and materials.
3. The deputy director of community services should work with the DDD personnel office to oversee the creation of these approved positions.
4. The director of the Community Services training unit should develop a systematic approach to incorporating DDD training programs into the region, researching and developing appropriate training modules for specific needs as they are identified, acting as a resource on training issues, having an impact on staff competency, and developing minimum standards to be used in the delivery of programs.

Training Source: Office of Human Resources and Development (OHRD), Department of Human Services (DHS)

1. Function

OHRD develops and implements required departmental training programs, ensures compliance with civil service regulations, and establishes special programs as requested by specific units.

2. Target Groups

DDD staff, community providers (selected programs), and DHS staff

3. Programs

- A. Instructor Training for First-aid and CPR
- B. Time Management
- C. Defensive Driving
- D. Crisis Recognition Prevention and Intervention (CRPI) and Follow-up
- E. Management Development Institute
- F. Pre-retirement
- G. Training for Trainers
- H. Stress Management
- I. Productive Meetings
- J. Effective Writing
- K. Workers' Right to Know
- L. Asbestos Control
- M. Affirmative Action

Recommended Action

The OHRD office should develop and implement a new employee orientation program for on-site delivery throughout the state.

Training Source: Department of Civil Service

1. Function

Civil Service Training is the designated office through which all statistical information on training must be reported. It serves as the approval agent for all training conducted outside the department.

2. Target Groups

DDD and DHS staffs

3. Courses

- A. Certified Public Management
- B. Secretarial Development
- C. Accounting I and II
- D. Business Writing Techniques for Secretaries
- E. Dictation and Transcription
- F. Error Recognition
- G. Executive Secretarial Seminar
- H. Introduction to ABC Shorthand
- I. Keyboard for Information Processing
- J. Records Control
- K. Secretarial Communications
- L. Secretarial English
- M. Secretarial Skills in Decision Making
- N. Shorthand Refresher (Gregg)
- O. Supervision—Clerical
- P. Speed Reading
- Q. Telephone Communications
- R. Typing Refresher

Recommended Action

DDD should continue to support the clerical enrichment program, which should be expanded to include clerical employees in Community Services and developmental centers.

Training Source: University of Medicine and Dentistry of New Jersey—Robert Wood Johnson Medical School (University Affiliated Facility)

1. Function

The University Affiliated Facility (UAF) develops and implements training programs to improve services for developmentally disabled individuals through interdisciplinary training of personnel, the provision of exemplary services relating to persons with developmental disabilities, research, and the dissemination of information about developmental disabilities.

2. Target Groups

DDD staff, community providers, DHS staff, consumers, parents, and professionals

3. Programs

- A. Developmental Disabilities Series
- B. Case Management
- C. Personal Care Attendant
- D. Leadership Management Seminar for Group Home Executives
- E. Nurses' Training in Developmental Disabilities
- F. Curriculum for Direct Care Workers in Developmental Centers
- G. Professional Development for Superintendents and Regional Administrators
- H. Time Management
- I. Training Program for Habilitation Plan Coordinators
- J. Health-Related Issues in Developmental Disabilities

Recommended Action

The recommendations listed below are predicated on the following variables: (1) the standardization of the CABI criteria and its being established as part of the overview, (2) the UAF's current commitments and availability of staff, (3) hiring realities (training for trainers), and (4) coordination with intake/eligibility time lines.

DDD should establish an agreement with the UAF for provision of the following:

- 1. Two-day orientation program on developmental disabilities including specific training on CABI for the southern regional office intake pilot (February 1986)
- 2. Two-day orientation program including specific training on CABI for intake personnel from other regions (fourth quarter, FY1986)
- 3. Orientation program on developmental disabilities for the central and regional DDD staffs (June 16-17, 1986)
- 4. Orientation program on developmental disabilities to train trainers (first quarter, FY1987)
- 5. Orientation program on developmental disabilities for key department staff (second quarter, FY1987)

Training Source: Special Contracts for Outside Resources

1. Function

Information and training are provided to DDD staff and community providers through the use of outside resources or through the development of specialized contracts.

2. Target Groups

DDD staff, community providers, staff from other divisions of DHS

3. Resources

- A. New Jersey state and county colleges
- B. Commission for the Blind
- C. Planned Parenthood
- D. American Red Cross
- E. YMCA
- F. Community hospitals
- G. Private agencies for specialized conferences and seminars
- H. DDD sponsored guest speakers (e.g., noted practitioners in various fields or experts from other divisions) and seminars
- I. Developmental centers
- J. Carrier Foundation
- K. Brain Injured Association
- L. Autistic Outreach
- M. Grant programs
- N. EIRC-South (Education Information Resource Center)
- O. DDD Office of Education

Recommended Action

DDD should investigate and use existing innovative training programs available through a variety of outside resources. Monies should be allocated for this purpose.

Training Source: Director, Community Training Programs, Central Office

1. Function

The director of community training programs coordinates the delivery of programs to division staff and community providers through regional training units. The director is responsible for maintaining quality assurance and compliance with Community Services policies and procedures.

2. Target Groups

DDD Community Services staff and community providers

3. Responsibilities

- A. Identifies training needs related to developmental disabilities within Community Services
- B. Secures programs to meet training needs through consultant contracting
- C. Develops training programs and ensures consistency and continuity throughout regional units
- D. Identifies potential sources of training programs and assists regional offices with their implementation
- E. Establishes a system within Community Services for acquisition of resources, supplies, and other training related activities
- F. Develops the annual training plan for Community Services
- G. Works with the DHS Office of Provider Relations and shares resources with other DHS divisions to secure conferences and training
- H. Develops mechanisms to evaluate curriculums
- I. Develops training standards for Community Services in conjunction with regional training units
- H. Provides specialized training and information seminars

Training Source: Director, DDD Residential Training Programs, Central Office

1. Function

The director of DDD Residential Training Programs ensures coordination within the division, provides technical assistance to developmental center training units, and serves as a consultant to the DDD director on training-related activities.

2. Target Groups

DDD staff, DDD central office division staff, and the developmental center at Ancora

3. Responsibilities

- A. Identifies training needs related to developmental disabilities throughout the developmental centers
- B. Secures programs to meet training needs through consultant contracting and the delivery of special direct training programs
- C. Processes all requests for special programs outside of DHS
- D. Coordinates DDD's participation in DHS's departmental and inter-departmental programs (e.g., Certified Public Managers Program, Nursing Scholarship, and Fels Institute)
- E. Develops the annual training plan for DDD's central office staff and the Ancora program
- F. Assists with Intermediate Care Facility (ICF) correction plans regarding training issues
- G. Serves as the DDD representative to the OHRD departmental training office for special programs

Training Source: Regional Training Unit Supervisor

1. Function

The regional training unit will be a new unit (one per region, two central regional offices) under the direction of the regional administrator. The supervisor of this unit will be responsible for supervising a regional training team that will initially consist of three trainers and one clerical worker.

2. Target Groups

DDD staff, community providers (group home, skill development, family care and respite workers), developmentally disabled persons, and families of the disabled

3. Responsibilities

- A. Identifies regional training needs
- B. Coordinates scheduling
- C. Conducts regional training plan
- D. Supervises training staff
- E. Develops procedures to comply with training standards
- F. Coordinates with the director of community training to ensure continuity and consistency of programs
- G. Coordinates registration of OHRD and Civil Service programs

Recommended Action

DDD should create four principal community program specialist positions by July 1, 1987. The specialists hired will establish a training implementation system for staff working with developmentally disabled individuals.

Training Source: Group Home Trainer

1. Function

A group home trainer (one per region) is primarily responsible for providing introductory, intermediate, and supervisory training programs to staff working in group homes, supportive living, and apartment programs. His/her responsibilities will expand to include the provision of division and department mandated programs for Community Services staff. Group home trainers will be supervised by the regional training unit supervisor.

2. Target Groups

Community Services staff and community providers working in group home and apartment programs

3. Programs

- A. Community Residential Staff Training, Level I—Introductory
- B. Community Residential Staff Training, Level II—Intermediate
- C. Community Residential Staff Training, Supervisory

4. Responsibilities

- A. Completes training evaluations
- B. Maintains training records
- C. Issues training certificates
- D. Serves on various committees for curriculum development and review
- E. Implements specialized programs as identified
- F. Implements overview of developmental disabilities to regional division staff and group home staff
- G. Provides coverage for other regional trainers

Recommended Action

By the end of FY1986, DDD will have licensed approximately two hundred group home and apartment programs. Staff turnover is estimated to be around fifty per cent. The number of group home trainers should be increased from three to four so that adequate training can be provided for staff members working with the new developmentally disabled population.

Training Source: Home Provider Trainer

1. Function

A home provider trainer (one per region, two central regional offices) is primarily responsible for providing a fifty-hour training program for skill development and family care applicants, as well as a sixteen-hour respite program for respite applicants. His/her responsibilities will be expanded to include the provision of division and department mandated programs for DDD staff. Home provider trainers will be supervised by the regional training unit supervisor.

2. Target Groups

DDD staff and skill development, family care, and respite providers

3. Programs

- A. Skill Development Applicant Training
- B. Respite Provider Training

4. Responsibilities

- A. Completes training evaluations
- B. Maintains training records
- C. Participates with home development unit in the final evaluation process when training is completed
- D. Maintains audio-visual equipment and training inventory
- E. Serves on various committees for curriculum development and review
- F. Implements specialized programs as they are identified
- G. Implements overview of developmental disabilities for regional division staff and skill and respite providers

- H. Provides coverage for other regional trainers
- I. Assists in the development and implementation of an applicant orientation program

Recommended Action

DDD should maintain the existing four home provider trainer positions.

Training Source: Staff Development Trainers

1. Function

The proposed staff development trainers' primary responsibility will be to provide training with an introduction to DDD clients, policies, procedures, etc., for all new employees in the division. Trainers will also deliver ongoing training to DDD staff in regard to the new population served by the division. Staff development trainers will report to regional training unit supervisors.

2. Target Groups

DDD current staff and new employees, clients, and parents

3. Responsibilities

Implementation of the following:

- A. Orientation to developmental disabilities for Community Services staff
- B. New employee orientation for Community Services staff
- C. Policies and procedures for abuse and neglect
- D. First-aid training
- E. CPR training (Cardiopulmonary Resuscitation)
- F. Orientation to new policies and procedures
- G. Affirmative action
- H. Specialized programs as they are identified

Recommended Action

Create four staff training positions (one per region, two central regional offices) to provide a service delivery system whereby regional division staff can receive training. Additional staff will be needed to provide appropriate staff training programs in regard to the new developmentally disabled population served by DDD.

RELATED SERVICES TASK FORCE

Task Force Charge

To survey the related service needs of non-mentally-retarded, developmentally disabled persons, e.g., homemaker services and respite care.

The task force will identify existing services and make recommendations for service utilization and program development to the Project Redirection Advisory Committee.

Introduction

The provision of related services is essential to many developmentally disabled persons' ability to live constructive lives. Although government cannot be expected to fully fund all related services, its provision of a single service will interact with and support the foundation of other services. This is the nature of supportive services—each service is not isolated but affects and supports other client services. Thus, some of the recommendations of this task force will overlap with those of other task forces.

Service provision to developmentally disabled persons has been fragmented. The network of services required by these individuals is neither complete nor coordinated. A case manager within the Division of Developmental Disabilities (DDD) structurally has the responsibility to coordinate a client's individual habilitation plan, but he/she has difficulty doing this for a developmentally disabled client because service networks are not in place. A case manager has to locate, gain access to, and link unassociated services, i.e., act as the coordinator and broker of client service systems. Therefore, a case manager has to devote a high level of time and effort to a developmentally disabled person. Trained case management staff must be available and caseloads must be small to ensure that the developmentally disabled individual's needs are adequately addressed.

Diane Mutchler, a member of this task force, is also a member of the Governor's Task Force on Services to the Disabled. Given the goals of the Governor's Task Force, its findings should complement the priorities set by the Related Services Task Force.

Due to the scope of the task force charge and the lack of an exact definition for related services, the task force began by identifying the specific services to be included in this category. (See the Related Services Task Force glossary for descriptions of the various related services.) Summary lists of high and moderate problems and service priorities for the physically disabled and developmentally disabled from the comprehensive service plans of eleven counties were surveyed. In addition, the following documents were reviewed: Executive Summary of the Governor's Council on the Prevention of Mental Retardation on Programs for Preventing the Causes of Mental Retardation; the National Association of State Mental Retardation Program Directors report, *Family Care for Persons with Development Disabilities: A Growing Commitment*; the New Jersey Developmental Disabilities Council's report from the Task Force on Family Systems; the York Associates' study, *Priority Areas of In-Home Family Support and Prototype Community Residence for Non-Mentally-Retarded Disabled*, and its report on the aging-out population. The recommendations of the DDD director, executive staff, and task force members are included in the Related Services Directory, which is the result of the effort to identify specific related services. (See Appendix I, Related Services.)

Issue Statement: Personal Care Attendant (PCA) Services

Some developmentally disabled persons can benefit from the services of personal care attendants. However, their needs vary. Some adult clients have the complete capacity to select and guide an attendant, but many do not. Various ways are being developed for a client or someone on his/her behalf to secure the services of a personal care attendant. The most available services are provided by the client's Medicaid entitlements through the New Jersey Division of Medical Assistance and Health Services. The Department of Human Services (DHS) is currently demonstrating several other models under the auspices of DDD and the County Offices for the Handicapped.

Statement of Need

Many developmentally disabled individuals need some physical assistance tailored to their unique functional limitations in order to live or work as independently as possible. However, many traditional service models tend to treat developmentally disabled persons as passive receivers of services rather than as people who can decide how services are to be designed and rendered. Current Medicaid regulations state that personal care services must be prescribed by a physician, delivered by a nursing care model, and limited to twenty hours a week. Hours of service are generally determined by the availability of a care provider rather than by the needs and/or preference of the developmentally disabled person. A service model that incorporates individualization of care and a methodology for personal care service needs to be developed and provided.

Recommended Action

1. Short Term (one year)

- A. DDD should coordinate its grants with those of DHS to ensure that duplication of effort does not occur. (This action is ongoing.)
- B. The Department of Human Services should issue a directory that identifies PCA programs, eligibility requirements, and application processes.
- C. The Division of Medical Assistance and Health Services should increase flexibility of the program by (1) extending the hours of service from the present limit of twenty to whatever number is needed by the developmentally disabled person and (2) giving control of the provision of service (scheduling of hours and tasks) to the client rather than the physicians and nurses.
- D. DDD should take steps to ensure a fair distribution of personal care services throughout New Jersey. Clients residing in counties without an Office of the Handicapped should have access to PCA services.
- E. DDD should assemble a PCA advisory committee, with a majority of developmentally disabled consumers, to help guide the development of PCA programming. The PCA advisory committee should make recommendations for an equitable distribution of resources and should assist in a program evaluation before the broader program implementation.
- F. DDD should have a representative on the PCA advisory committee.

2. Long Term

- A. Standards for adequate training of PCAs should be established by DDD.
- B. The question of licensing PCAs should be investigated by DDD.
- C. DDD should take a leadership role to ensure that a broad range of PCA programs are available to meet the individual service needs of clients.

D. Insurance coverage for services of PCAs should be clarified by DDD.

E. DDD should investigate and support the availability of third-party payment for PCA services.

See the Employment Task Force report for recommendations regarding the use of PCA's in employment settings.

Staff Responsible for Implementation

Donald Zdanowicz, Coordinator, Social Services, Central Office
Laurene Ryan, Home Assistance Coordinator, Central Office

Issue Statement: In- and Out-of-Home Respite Care

More persons with developmental disabilities reside with their families than in alternative living arrangements. However, the majority of service dollars are spent on out-of-home residential alternatives. Therefore, providing services that encourage a client's residing with family members is cost-effective.

Statement of Need

Families of persons with developmental disabilities need relief from continuous care-taking responsibilities. Throughout the reviewed reports and studies, respite care emerged as a high-priority service need. However, respite service is often provided on the basis of what is available rather than on an individual's need. In addition, respite care that promotes a client's ability to direct the service is not a ready option.

Recommended Action

1. Short Term (one year)

- A. DDD staff should identify statewide the existing respite programs that serve developmentally disabled persons and communicate this information to regional staffs.
- B. DDD should establish minimum training standards for respite care provided under its auspices to ensure that appropriate care is rendered to clients. The standards should reflect that clients vary in their needs and ability to self-direct and that care providers need appropriate training for meeting these diverse needs and abilities.
- C. DDD should eliminate the present thirty-day time constraint for each client and family within the respite program.
- D. DDD should modify the financial eligibility criteria of the respite program so that it is not a barrier to needed service. Community Services has proposed new guidelines that set program eligibility limits at 125 per cent of New Jersey's 1983 median income (the most recent figure available). This increase in eligibility limits should reduce the barrier to service and is supported by this task force.
- E. DDD should assess the effectiveness of the thirteen in-home family support grants for continuation and/or replication.
- F. DDD should expand funds available within the Home Assistance respite program. Funds should be provided for additional staff and advertising.

2. Long Term

- A. DDD should review program models and develop and maintain in accessible locations a variety of respite alternatives to meet the diverse needs of individuals. Respite alternatives should be available for as long as a client is able to self-direct.
- B. The respite program of DDD should focus on support needed to prevent a client's inappropriate move from his/her residence.

Staff Responsible for Implementation

Donald Zdanowicz, Coordinator, Social Services, Central Office
Laurene Ryan, Home Assistance Coordinator, Central Office

Issue Statement: Life Skills Education—Techniques for Disabled Persons

Traditionally, persons with developmental disabilities have not had the opportunities and experiences to obtain the knowledge and practical skills needed to conduct daily life activities. Skills training is most beneficial when it is started in a client's primary years and provided on a continuing basis into his/her adulthood. However, persons with developmental disabilities who are now adults were not provided with this skills training during their formative years. Thus, a high priority must be given to compensating for this lack of training. Life skills education for all developmentally disabled adults is essential for their achieving their maximum potential.

Statement of Need

Children and adults with developmental disabilities need life skills programs and special techniques to enable them to perform routine daily activities.

Recommended Action

1. Short Term (one year)

- A. DDD, through its Office of Community Education and through efforts with the Office of Education in the Department of Human Services, should develop a curriculum with interesting subject matter on developmental disabilities for local school boards to use when choosing topics for their family life education programs. This curriculum should also be distributed through professional organizations, e.g., The National Teachers Association.
- B. Driver's training and vehicle adaptive equipment should be available to DDD clients and funded through the expansion of the DDD Home Assistance program for persons who are not eligible for these resources by other means.
- C. DDD should contact and use existing experts and resources, e.g., ABLEDATA and National Rehabilitation Information (1-800-346-2742), for technical methods and adaptive devices that afford more independence and mobility for persons who are developmentally disabled. Information should be disseminated through training provided for DDD staff.
- D. DDD should initiate, through contracts already established, the use and/or expansion of programs that use a functional level model for life skills development.

- E. DDD should assess developmentally disabled clients' needs for the provision of equipment and/or services by rehabilitation specialists (e.g., occupational therapists) and provide funding for these needs when no other source is available.

2. Long Term

- A. Many community colleges and Ys offer adult education courses and general human enrichment courses, e.g., cooking, home maintenance, family and parent training, recreational instruction, budgeting and career development. DDD should work with the Department of Higher Education and local boards of education to encourage them to make these programs accessible to persons with developmental disabilities.

Staff Responsible for Implementation

Doris Wilson and John McGhee, Program Support Coordinators
Regional unit directors of Program Support Units

Issue Statement: Health Care

Developmentally disabled persons frequently have complex health care needs that require the professional services of a multiplicity of health care specialists working as a team. Unlike the mentally retarded adults currently served by DDD, many developmentally disabled children and adults may not be eligible for SSI/Medicaid payments for these services. Consequently, their access to health care services is impeded by limited coverage or no third-party resources.

The availability of and access to quality, integrated health care services for adults differs considerably from that for children. A system of health care for children is in place in the Departments of Health and Education, although present funding levels for the existing services are not sufficient to meet the demand for them. Therefore, for children the problem is not the availability of services but gaining access to them.

On the other hand, the unavailability of treatment services for adults is a major issue. There is no network of integrated specialized health care services for adults like the system that exists for children. Services must be purchased on a fee-for-service basis from a variety of vendors, who may or may not have expertise in applying general principles to specific disabilities and functional limitations.

Statement of Need

Access to quality integrated health treatment services for children must be improved. A state-wide network of quality health care service providers using an interdisciplinary approach to meet the specialized needs of the adult developmentally disabled population must be developed and made available and accessible.

Recommended Action

1. Short Term (one year)

- A. DDD staff should investigate models of delivery systems for health care services for DDD adults and look for a model that offers controls on both quality and cost.
- B. DDD staff should meet with Department of Education (School Health and Special Education) and Department of Health (Special Child Health Services) personnel to determine the specific economic barriers that deny children access to services and make recommendations for the elimination of these barriers.

2. Long Term

- A. An appropriate staff should be assigned to study and make recommendations for eliminating gaps in health services for adults and children served by DDD.
- B. DDD should make provisions to ensure that the individual health care needs of its clients are met.

Staff Responsible for Implementation

Rosemarie Zarlengo, Coordinator, Nursing Services
Regional and Day Training nurses

Issue Statement: Legal Advice and Consultation

Persons who are developmentally disabled have numerous legal problems that differ from those of other discrete segments of the population and from the public in general. There is, in addition to the laws that are applicable to all people, a large and complex body of laws specifically for the benefit of disabled persons. However, because of the nature of many developmental disabilities, disabled individuals often are not able to assert their rights and are vulnerable to abuse and exploitation. Furthermore, because of the emphasis on community care and the resultant dispersal of developmentally disabled persons throughout society, monitoring the legal status and needs of these people is difficult.

Statement of Need

As indicated in the issue statement, developmentally disabled persons are unusually dependent on the protection of the legal profession. However, because there is little financial reward from serving these clients, lawyers in private practice have never been able to meet the needs of the disabled. Nor have the traditional federally funded legal services programs. Designed primarily to serve the general population of poor people, these programs have rarely, if ever, focused attention on developmentally disabled persons. The Public Advocate's Division of Advocacy for the Developmentally Disabled responds well to its legislative mandate, but it tends to focus on systematic problems that are often institutional rather than on the legal needs of individuals.

Recommended Action

1. Short Term (one year)

Secure statewide legal representation for developmentally disabled individuals residing in the community. Contract with an organization experienced in the provision of legal services to disabled persons—particularly developmentally disabled persons. Community residents should be the focus of the legal services, since they currently have the least access to such services and are the most numerous among the developmentally disabled population. (This action has been accomplished.)

2. Long Term

Continue on a statewide basis to provide legal services for developmentally disabled community residents and combine these services with an educational program designed to better inform clients, their families, and DDD staff about the impact of legislation on developmentally disabled persons.

Staff Responsible for Implementation

Daniel Vaughn, Executive Assistant to the Director

Issue Statement: Social Recreation and Leisure

Persons with developmental disabilities have many leisure hours but few leisure skills. They need recreational opportunities that promote social, physical, emotional, and intellectual development.

Statement of Need

Although special programs exist in areas such as organized camping, diverse recreational activities should be available on a routine basis to persons with developmental disabilities. The Association for Retarded Citizens has routine recreational programs that include bowling, swimming, women's and men's groups, and dinner clubs. But these programs rarely serve those with other developmental disabilities and do not integrate the disabled with the non-disabled population. Recreation and leisure programs for developmentally disabled persons should include activities that are available to the community as a whole.

Recommended Action

1. Short Term (one year)

- A. DDD Community Services staff should refer their clients with recreational needs to the county chairpersons of Project Network. Project Network has been designated by the New Jersey Commission on Recreation for the Handicapped as a county-based source for information dissemination, technical assistance, and service coordination of recreational and leisure services for disabled persons. This project also coordinates existing recreation services within and between counties. (See Appendix II, Related Services.) Members of Project Network include recreation service providers, community agency personnel, parents, educators, advocates, and disabled citizens.
- B. The Revised New Jersey Barrier Free Regulation will be published in the New Jersey Register. The regulation includes a section on the accessibility of recreational facilities. DDD should review this regulation when it is published and include in its comments support for the section pertaining to accessibility of recreational facilities. (The revised Barrier Free Regulation has been published. DDD reviewed it and submitted comments at a public hearing.)
- C. Model programs for intellectually capable developmentally disabled persons (e.g., Monmouth County Parks and Recreation Department, Camp Daisy of East Brunswick, New Jersey Tournament of Champions, and Very Special Arts New Jersey) should be supported. These and similar model programs were highlighted at the Developmental Disabilities Council's Family Recreation Day for the Disabled on March 15, 1986.

2. Long Term

- A. Funding should be provided through a state appropriation to DDD for innovative and underused recreational programs, such as horseback riding for the disabled—an activity in which severely disabled persons can participate from childhood through adulthood.
- B. The adaptation and expansion of existing recreational programs to include persons with developmental disabilities should be encouraged. This should be done by shared

- funding and resources to provide any special materials and equipment needed by disabled persons if they are to enter into the mainstream of activities. The provision of programs tailored to individual needs and performance should also be encouraged.
- C. A representative of DDD should serve on the Recreational Services Council of the New Jersey Commission on Recreation for the Handicapped and with the county-based Project Network. DDD will thus be able to contribute to recreational policies, program decisions, and program networking.

Staff Responsible for Implementation

Division director, designee
Regional administrator, designee

Issue Statement: Service Delivery Model

The developmentally disabled population is a complex group of individuals who, by definition, need "a combination and sequence of special interdisciplinary or generic care, treatment or other services which are of life-long or extended duration and are individually planned and coordinated." To address this client need, a model of service delivery has to be developed at the local level to ensure that each individual receives a proper assessment and is provided with the appropriate client services. The model also has to be flexible enough to provide a continuum of appropriate services.

Statement of Need

Related services cover a wide spectrum of client needs. However, despite the well-meaning efforts of providers, many developmentally disabled individuals receive inadequate or inappropriate services. This, in some measure, is due to the lack of assessments, follow-up procedures, and evaluations by professionals knowledgeable about the various service needs of persons who are developmentally disabled. In addition, because mentally retarded clients generally present inadequate ability to self-direct, DDD's Individual Habilitation Plan (IHP) has limited client involvement.

Recommended Action

1. Short Term (one year)

- A. A formal evaluation by appropriate staff and information contributed by the client should form the basis of IHP development. DDD should ensure that a comprehensive number of professionals will be available to perform assessments, recommend individual program development, complete evaluations within the various disciplines, and function as an interdisciplinary team with the client as a member. (This action has been started and is ongoing.)
- B. To determine types of evaluations and re-evaluations needed when a client presents specified functional limitations and developmental disabilities, DDD should designate an appropriate staff to review literature and programs currently serving developmentally disabled persons. Findings should be included in staff training. (This should be done by September 1, 1986.)

2. Long Term

A comprehensive coordinated model of service delivery for developmentally disabled clients that promotes their self-direction and fosters the availability of appropriate

individual program planning, implementation, and evaluation should be developed and implemented by January 1, 1987.

Staff Responsible for Implementation

Regional unit directors of Case Management and Program Support

EMPLOYMENT

Task Force Charge

To examine the employment needs of non-mentally-retarded, developmentally disabled individuals. To include an examination of existing in- and out-of-state work programs, with an emphasis on interfacing with private industry.

The task force will report to the Project Redirection Advisory Committee its findings on ways to strengthen existing employment opportunities for non-mentally-retarded, developmentally disabled persons and will recommend alternative models.

Introduction

The Employment Task Force was charged with examining the needs of non-mentally-retarded, developmentally disabled individuals. The task force defined "employment" as competitive employment with earning levels at minimum wage or above. With this definition in mind, in- and out-of-state training programs and placement initiatives were examined. Emphasis was placed on interfacing with private industry.

Several major areas of focus emerged as critical for effecting the movement of developmentally disabled individuals into the work force. These areas included support services, rehabilitation engineering, interfacing with other components of state government, outreach, public relations, and assessment of other state systems and training programs.

Issue Statement: Support Services

Persons with developmental disabilities have employment needs that have not been adequately addressed to date. The cost of maintaining these individuals in day programs can be prohibitive. Thus, if clients who are capable of competitive employment receive services to assist them in achieving that employment, there will be a significant cost saving. Not only will these individuals be achieving their highest vocational potential, but the resultant cost savings can be used for additional services for those people who are incapable of employment.

Statement of Need

Persons with developmental disabilities need specific support services if they are to realize their potential to acquire and retain competitive employment. If the following support services are made available as needed to clients, families, and employers, this potential will be maximized.

1. **Job coaching.** Job coaches provide on-the-job training for the client at the job site. This training usually includes a job analysis that identifies specifics of the job and accessibility factors. The job coach also takes responsibility for familiarizing the employer with the needs of the client and the availability of tax credits.
2. **Transportation.** Transportation is one of the most essential support services for successful job acquisition and retention. A viable means of transportation must be identified and provided for each client. This may be as simple as training an individual to use available public transportation that already exists or as complicated as providing transportation where none exists.

3. **Family participation.** A family's support and its commitment to furthering the employability of the client is essential. Group home providers, skill development sponsors, and significant others should also be included in the client's support group. The solicitation of this support and commitment will require a coordinated effort from the client's case manager and job coach.
4. **Program assurance.** If a client is not successful in a job placement, he/she should be allowed reentry into an appropriate program to overcome the issues that caused his/her failure. In all cases, the vacated job slot should be filled to minimize the employer's difficulties and to guarantee the employer's future cooperation with the program.
5. **Personal care attendant (PCA).** PCAs provide for physically disabled individuals essential support that opens doors to employment opportunities that otherwise would be unattainable.

Recommended Action

1. **Short Term (one year)**
 - A. Because Project HIRE (Handicapped Individuals Requiring Employment) currently has most of the support services identified above, it should be expanded to include the non-mentally-retarded, developmentally disabled population in FY1987.
 - B. Alternatives to supported work should be developed by the Division of Developmental Disabilities (DDD) for clients who are unable to benefit from Project HIRE. A Request for Proposal (RFP) should be generated to encourage the development of creative alternative work opportunities for this population.
 - C. Currently four pilot projects have been developed for the provision of PCAs. Due to the importance of PCAs to physically and developmentally disabled individuals, a referral mechanism should be developed to enable clients to obtain their services. (See the Related Services Task Force report for specific recommendations regarding PCA services.)
2. **Long Term**
 - A. An industrial advisory council should be developed. This council should be comprised of business and industry personnel who will advise DDD on such topics as qualifications needed for certain jobs, curriculum development, on-site preparation, length of training, and employer recruitment.
 - B. An ongoing evaluation system should be instituted to ensure that employment projects remain on target and problem issues that arise are attended to immediately. Results should be closely monitored to make certain that projects meet or exceed stated goals. The evaluation should be performed by a professional research organization, e.g., Mathematica.

Issue Statement: Rehabilitation Engineering

From medical and engineering technology of the space age have come devices that enable many severely disabled persons to increase their level of functioning and become employable. Almost anything that a person can accomplish cognitively can be accomplished physically, with the aid of technology. The professionals and the developmentally disabled persons they serve need to be made aware that such technology exists, and the technology must be made more available to disabled persons.

Statement of Need

Although the technology exists to make it possible for even severely disabled individuals to become more independent and employable, such technology may never reach the persons who need it. In some cases, this is for economic reasons. More often, the needed device is quite inexpensive, but the disabled person and/or the professional working with him/her does not know that the device exists, or where and how to obtain it.

Recommended Action

1. Short Term (one year)

- A. Purchase the services of a rehabilitation engineering consultant to assess the specific needs of DDD and to advise on the development of a system to provide, on a statewide basis and as needed, rehabilitation engineering services. This should be accomplished as soon as possible in FY1987 so that an implementation plan can be developed.
- B. Based on the first recommendation, hire a full-time rehabilitation engineer or contract with a locally based consultant for sufficient time annually to meet statewide the needs of DDD clients. This should be done as soon as possible.
- C. Develop a list of resources and training topics in the field of rehabilitation engineering. Extensive work has been done in this area. In order to prevent duplication of efforts, use should be made of already existing resources and services. For example, the Wisconsin Vocational Studies Center of the University of Wisconsin has a manual on tools, machinery, and equipment developed for disabled persons. The Job Development Laboratory of George Washington University also has a variety of audiovisual programs and publications. A subscription to computer networks, particularly ABLEDATA, is extremely useful. Finally, contact professional organizations working in the area, such as the Rehabilitation Engineering Society of North America (RESNA) and the Association for Rehab Engineering and the Advancement of Technology. Lists of resources should be updated and disseminated periodically.
- D. Develop and implement a conference to familiarize participants with rehabilitation engineering, including state-of-the-art techniques, technology, and programs. The lead organization for planning this conference can be the UAF, an agency with experience in using rehabilitation engineering (e.g., Matheny School), or a combination of the two. DDD staff should be given priority for participation in this conference, but providers and consumers will also be able to attend.

2. Long Term

Develop an equipment bank to recapture equipment no longer being used, thereby increasing availability and cutting costs.

Issue Statement: Interfacing With Other Components of State Government

People with developmental disabilities need a wide array of services to help them obtain and sustain employment. The agencies and providers serving this population must work together to facilitate the placement of developmentally disabled individuals in competitive jobs. They should also work together to help disabled persons achieve their maximum potential, which for many may be a job.

DDD supports the concept that it should work with other state agencies responsible for the employment of disabled citizens. This interaction will avoid duplication of existing services known by clients and providers who are already involved in securing employment. A greater effort should also be made to inform other providers and various government departments about these existing services. Cooperation between DDD and other state agencies will result in a better plan for expansion of services to meet the needs of individuals who will be served best by a supportive competitive work component.

Statement of Need

Employment is secured through the use and orchestration of the various state departments that are charged with providing services. DDD, the Division of Vocational Rehabilitation (DVR), the Department of Labor, the Department of Education, and others in concert with service providers, such as the Association for Retarded Citizens (ARC) and United Cerebral Palsy (UCP), must assist the developmentally disabled individual with securing those services needed for him/her to obtain employment.

Individuals who are developmentally disabled need services provided through all departments in order to obtain and sustain employment. However, there is currently no formalized communication mechanism between the various departments of state government for reviewing these services. In fact, the case manager is the only broker who is available to review them. Therefore, the client's access to the services available through different state agencies is dependent on a case manager's skills and knowledge of the existing service network. A systematic approach is needed to develop and maintain open lines of communication for services available through various departments of state government.

Recommended Action

1. Short Term (one year)

The governor recently appointed a task force comprised of individuals from various groups: consumers, parents, private providers, legislators, and members of departments of state government. This task force was charged with studying the needs of and resources available for New Jersey's disabled population and developing recommendations for a coordinated model of services supported by appropriate funding. DDD should continue to support this task force as a means for beginning the interfacing and networking pertinent to job-related issues and needs.

2. Long Term

- A. In order to facilitate and foster a better method of communication to assist developmentally disabled persons with employment needs, interagency agreements should exist between the Departments of Human Services, Labor, and Education. The agreements should include the following:
 - (1) Between DDD (Department of Human Services) and DVR (Department of Labor): an agreement that appropriate referrals of clients and fiscal support will be determined by which agency can best provide the service needed by the client. This will be accomplished by a committee whose membership will include representatives from DDD, DVR, and the New Jersey Association of Rehabilitation Facilities.
 - (2) Between DDD (Department of Human Services) and the Divisions of Vocational Education and Special Education (Department of Education): an agreement to support transitional programs by developing on-the-job training for severely disabled students who will be eligible to enter the work force at age twenty-one.

- B. DDD should support federal and state legislation to promote tax credits for supportive employment.
- C. DDD should support the continuation of sections 1619-A and 1619-B of the Social Security Act.
- D. DDD should begin to identify resources for those developmentally disabled individuals who will benefit from obtaining a college or post-graduate degree leading to professional employment. The cooperation of the Department of Higher Education should be sought to accomplish this goal.
- E. DDD should be involved in the planning of the proposed college for computer technology to ensure that this educational facility will adequately address the needs of developmentally disabled persons in the state of New Jersey.

Issue Statement: Outreach and Public Relations

Persons with developmental disabilities living in the community are in need of employment services. If there is to be a successful placement of these individuals in competitive employment, outreach and public relations efforts in the community will be necessary.

Statement of Need

A concentrated statewide public relations effort directed toward the business community is needed to promote the hiring of developmentally disabled persons.

Recommended Action

Short Term (one year)

- A. A brochure describing the capabilities of the developmentally disabled population and the benefits of employing them should be developed for distribution to potential employers.
- B. The Office of Community Education should implement a statewide public relations campaign. The campaign should be a cooperative effort by all appropriate agencies and should include the following:
 - Feature stories in all major New Jersey newspapers
 - Radio spots
 - Television coverage
 - Mass distribution of brochures
 - Press releases
 - Information packets to major employers
 - Speaking engagements at civic organizations, such as the Rotary Club and the Elks
 - Relationships with local chambers of commerce, PIC councils (private industry councils), county vocational service coalitions, etc.

Issue Statement: Assessment of Information on Other State Systems

Many programs and organizations are developing and delivering vocational services to the non-mentally-retarded, developmentally disabled populations. The New Jersey DDD presently has only limited information on some of these programs.

Statement of Need

DDD needs to gather and analyze information from educational, advocacy, and vocational organizations in New Jersey and throughout the nation to identify the appropriate services to be provided and to determine the most effective way to provide these services.

Recommended Action

1. Short Term (one year)

- A. Assign a staff to gather and analyze program information from the New Jersey and other state systems.
- B. Meet with agencies referring or receiving referrals to clarify their responsibilities and expectations and to ensure that a continuum of services will be available.

2. Long Term

Encourage and financially support the participation of DDD staff in conferences that provide current information on vocational services in other states. This will ensure that New Jersey's programs reflect the best services available.

Issue Statement: Training

Individuals with developmental disabilities who reside in the community have a need for vocational training within the current service system. Through the use of a spectrum of training areas, the employment process for developmentally disabled individuals can be enhanced. In regard to training for employment, parents, staff, and other professionals need to change their attitude toward disabled persons and their expectations and aspirations for them.

Statement of Need

A change in focus relative to the employment of developmentally disabled individuals must occur at every level of the service delivery system. This, in turn, will effect changes from the educational to the vocational setting. Although DDD has made creative changes in the development of vocational options, e.g., Project HIRE and funding of DDD clients in sheltered employment, there is still a need to expand activities relative to employment for the developmentally disabled population as a whole. Before actual expansion of activities, appropriate training to facilitate and coordinate a generic service system for developmentally disabled individuals should be provided for consumers, staff, parents, and the general community.

Recommended Action

1. Short Term (one year): Staff

A. Incorporate the following items into training programs for appropriate staff:

- (1) Staff training concerning non-mentally-retarded, developmentally disabled individuals
- (2) Assessment of employment opportunities within geographical areas of client residence
- (3) Training in vocational evaluation instruments (evaluation and types of training offered by sheltered workshops)
- (4) Familiarity with work-related behavior of the client to help him/her successfully adapt to a job
- (5) Staff training in the DVR system and services

B. Develop a coordinated employment resource directory specific to each region. The development of a directory will be accomplished by a committee whose members may include but not be limited to representatives from UCP, DDD, associations concerned with education, epilepsy, autism, and spina bifida, and local businesses. This directory should be periodically updated.

2. Long Term: Staff

Develop a regional liaison who will be responsible for maintaining active contacts with sheltered workshops, employers, community leaders (e.g., PIC Council), and other agencies that deal with activities related to employment (e.g., Job Training Partnership Act). This liaison will also be responsible for the ongoing evaluation and implementation of regional staff training needs relative to the employment of developmentally disabled individuals.

3. Short Term (one year): Parent, Guardian, and Caretaker

A. Develop training opportunities for parents that include the following:

- (1) Parental involvement beginning with the early education of developmentally disabled individuals
- (2) Training in vocational alternatives
- (3) Training in the social security system as it relates to employment
- (4) Parental involvement in employment planning
- (5) Training in client use of transportation alternatives to gain access to employment
- (6) Training to evaluate parental expectation of a developmentally disabled individual's ability to be successfully employed

4. Long Term: Parent, Guardian, and Caretaker

Develop a parent support and advisory group specifically related to employment activities of family members.

5. Short Term (one year): Client

A. Incorporate the following into existing day programs and/or placement initiatives:

- (1) A work ethic where appropriate
- (2) Job-seeking skills, such as filling out applications and interviewing

- (3) Job-keeping skills pertaining to response to supervision, appropriate behavior, personal appearance, motivation for employment, and mobility
- (4) Over-all training commensurate with the client's actual job
- (5) Training in the use of generic community resources (e.g., physicians, local vendors, and financial institutions)
- (6) Training in consumer awareness behavior (e.g., budgeting and shopping)
- (7) Job exploration and experiences

6. Long Term: Client

- A. Appointment of a task force including but not limited to members of DDD, DVR, and the Department of Education to assess the adequacy of and make recommendations to improve the early education of developmentally disabled students in vocational and employment preparation
- B. A change from traditional approaches to integrated training or exposure to natural work settings
- C. Development of more sophisticated work stations based on industry models
- D. Expansion of traditional sheltered workshop activities
- E. Conversion of crew labor to include more realistic employment expectations followed by an expansion of the crew labor program

GUARDIANSHIP/ADVOCACY/ SELF-DIRECTION TASK FORCE

Task Force Charge

To look at the potential consumer population in relation to self-direction issues (fostering self-direction and participation in decision-making) and develop strategies to support clients in these areas.

To examine the current guardianship legislation, policies, and practices in relation to mentally retarded persons and the newly eligible non-mentally-retarded, developmentally disabled population. The task force will develop all changes and modifications needed in guardianship policies and practices and recommend these changes and modifications to the Project Redirection Advisory Committee.

To review the effectiveness of advocates and advocacy systems for developmentally disabled persons and to formulate recommendations for enhancing and broadening their impact.

Introduction

All persons possess certain basic human and civil rights. Individuals differ, however, in their ability to exercise these rights.

Developmentally disabled adults have a broad spectrum of differences relative to their personal capacities in the exercise of human and civil rights. Some developmentally disabled individuals are perfectly capable of acting independently in this regard. Others may be so severely impaired, physically and/or mentally, that they cannot make even the most basic decisions for themselves.

With respect to developmentally disabled adults already being served or to be served by the Division of Developmental Disabilities (DDD), the task force identified three categories of responsibility that the division has in regard to clients' rights:

1. In some instances, developmentally disabled clients may need the support, assistance, and environment to enable them to advocate for themselves and to exercise and increase their own independent decision-making.
2. Less capable clients may need individuals or organizations to advocate on their behalf because of their reduced effectiveness to do so for themselves.
3. Developmentally disabled persons with the most serious deficits will need the legal appointment of a substitute decision-maker—a guardian—to act on their behalf in the exercise of their rights.

The following issue statements and recommendations address specifics that apply to each of these three areas.

Issue Statement: Guardianship

The exercise of rights by a developmentally disabled person may sometimes require the appointment of a guardian whose role and responsibility is to make substitute decisions on behalf of the disabled person to protect his/her rights, interests, and welfare. Guardianship is a legal provision designed for persons who lack competence to govern themselves and manage their own affairs.

Statement of Need

The many individuals, groups, agencies, and organizations relating directly or indirectly to DDD and its clientele need clear, accurate, and comprehensive information about the meaning of guardianship, the role and responsibility of the guardian, and procedures for the appointment of a guardian.

Recommended Action

1. Short Term (one year)

- A. A training module for guardianship should be developed by May 1, 1987, by a special committee chaired by a staff person from DDD's training unit. This committee should include representation from the Bureau of Guardianship Services (BGS), the Department of the Public Advocate (Division of Advocacy for the Developmentally Disabled [DADD]), a Community Services Case Management Unit, the developmental center's Social Services Department, DDD's Speaker's Bureau, the Community Health Law Project, and the University Affiliated Facility (UAF). A parent and a service provider should also be involved.

The content should include but not be limited to the following:

- (1) Need for guardianship and how this differs from need for services, support, advocacy, etc.
- (2) Meaning of incompetency
- (3) Fitness of a guardian
- (4) Overprotection and the right to risk
- (5) Informed consent
- (6) Ethical considerations in medical treatment
- (7) Community resources
- (8) Individual Habilitation Plan (IHP) process
- (9) Appeal procedures
- (10) Limitations of a guardian
- (11) Examples of forms requiring guardian's signature
- (12) Guardian's relationship to DDD
- (13) Accountability of a private guardian to DDD
- (14) Philosophy of habilitation, normalization, least restrictive alternative
- (15) Client's loss of rights
- (16) Client participation in decision making
- (17) Reversal of guardianship
- (18) Community trusts

- B. The task force recommends that DDD

- (1) Develop a manual on guardianship for distribution to parents and private guardians. (This has been done.)

- (2) Provide through the BGS regional offices an ongoing consultation service for private guardians; inform the public about this service through the dissemination of the guardianship manual, information when a guardian is appointed, advocacy training seminars, and information during the course of the intake process. The addition of one BGS specialist in each of the three BGS regional offices will make this consultation service feasible.
 - (3) Assume (by May 31, 1987) a leadership role in the formation of peer support groups for private guardians. An active part should also be played by DADD, the Association for Retarded Citizens (ARC), and parents' associations.
- C. The task force recommends that DDD, perhaps in conjunction with the UAF, gather (by May 31, 1987) information to be used as a basis for determining the possible benefits of amending the current guardianship law for developmentally disabled clients of DDD to include provision for limited guardianship. One aspect of limited guardianship that should be particularly scrutinized is guardianship of property. A two-part study should be conducted:
- (1) The decision-making capabilities and deficiencies of a cross-section of marginal, *grey area* clients should be analyzed. This group should include clients deemed legally competent but with questionable judgment in certain areas, as well as others who have guardians but exhibit some degree of competence in making decisions. In regard to the latter, guardians should be urged to consult with clients and solicit information from them during the decision-making process.
 - (2) A systematic survey of those states that currently have limited guardianship laws should be conducted to determine advantages, disadvantages, and workability of existing provisions for limited guardianship.
- D. The task force recommends that DDD formally advocate for passage of protective services legislation for vulnerable, developmentally disabled adults. (The task force is formally endorsing bills A. 289 and A. 70.) The legislation should incorporate the following elements:
- (1) Assignment of responsibility for investigating allegations of abuse, neglect, and/or exploitation
 - (2) Mandatory cooperation by law enforcement officials, as needed, during investigation or intervention
 - (3) Provision for expedited court procedures permitting swift action in life-threatening situations or when there is risk of serious physical harm
 - (4) Designation of persons required to report abuse and/or neglect, sanctions for failure to report, and immunity from liability if a report is made in good faith
 - (5) Stipulation of the right of legal access to private residences by authorized staff and prescription of penalties for interfering with investigations
 - (6) Protections for confidentiality of abuse and/or neglect reports and hearings
 - (7) Requirement for informing licensing authorities when abuse and/or neglect by a licensed service provider has been substantiated
- E. The task force recommends the planning and preparation (by May 31, 1987) of a professional conference for judges. The conference will focus on issues and topics pertinent to developmental disabilities and guardianship.

2. Long Term

A. Implement guardianship training for

- (1) Professional staff employed by DDD and by service provider agencies under contract with DDD
- (2) Other agencies and organizations serving the developmentally disabled
- (3) Family care and skill development home sponsors
- (4) Parent groups and private guardians

B. Formulate (by January 1, 1988) recommendations for limited guardianship legislation based on findings of completed study

Issue Statement: Advocacy

Developmentally disabled adults are often competent to make decisions on their own behalf and consequently are not in need of guardianship. Nevertheless, they may require advocates and advocacy systems to ensure their rights in terms of access to services and entitlements for which they are potentially eligible.

Statement of Need

1. Advocates and advocacy agencies—particularly those involved with developmentally disabled persons who are not mentally retarded—need to be informed about available programs and services that can meet the needs of these individuals. They also have to know how to apply for these services, the criteria for eligibility, the locations of intake offices, etc. It is impossible to advocate without awareness of what to advocate for and how to apply for these services.
2. Advocates and advocacy agencies frequently lose effectiveness because they are spread out and isolated. These disparate individuals and groups need to coalesce and integrate their efforts and activities in order to achieve greater *clout*—especially when they have a coincidence of needs and objectives—regardless of the specific type of developmental disability that is their concern.

Recommended Action

1. Short Term (one year)

- #### **A. The task force recommends that training seminars on advocacy for developmentally disabled persons be provided (by June 1, 1987) on a regional and county-by-county basis to agencies and individuals. Participants should include representatives from local chapters or units of organizations involved with developmentally disabled people (e.g., United Cerebral Palsy [UCP], the Epilepsy Foundation, the New Jersey Council of Organizations and Schools for Autistic Children and Adults [COSAC], and the Association for Retarded Citizens [ARC]), school social workers, Division of Vocational Rehabilitation (DVR) counselors, and County Offices for the Handicapped. The regional offices of Community Services should plan and organize these seminars, but the actual content should be developed by a team involving DDD's Office of Community Educa-**

tion, DADD, Citizen's Advocacy, and a provider agency. Areas to be addressed should include

- (1) Techniques and strategies for effective advocacy
 - (2) How to gain access to the service system
 - (3) Procedures for applying for services
 - (4) Eligibility criteria
 - (5) Appeal process
- B. The task force recommends that DDD assume a leadership role in encouraging, facilitating, and coordinating initiatives whereby local chapters or units of UCP, the Epilepsy Foundation, COSAC, ARC, and other organizations form local advocacy coalitions. Again, this effort will be made on a grass roots, county-by-county basis, but it can also take the form of regional coalitions. The Human Services Advisory Council can be a point of departure and/or an avenue toward the formation of these coalitions, which can also be facilitated through the use of training materials available through the UAF. The Self-Help Clearinghouse should also be addressed in this regard. The purpose of this activity is to consolidate advocacy efforts addressing needs common to these agencies, such as housing, education, training, transportation, and home assistance. (This action will take place by June 30, 1987.)

2. Long Term

The task force recommends as a long-range goal the establishment of a statewide advocacy system for developmentally disabled persons in the form of a private, non-profit agency. There should be a plan for phasing out the role of DDD in encouraging, facilitating, and coordinating development of such a system. This phase-out plan should be organized along regional or county (two or three counties) lines and include employed professional staff as well as volunteers. Funding should be from sources external to state or other public agencies. The major thrust will be to advocate for developmentally disabled persons and facilitate their access to the services, resources and entitlements that address individual needs.

Issue Statement: Self-Direction

Many persons with developmental disabilities are perfectly capable of securing, exercising, and safeguarding their own rights and entitlements if they are given the proper framework within which to achieve maximum self-direction and practice self-advocacy.

Statement of Need

DDD can and should establish and maintain those key elements in programs under its control that will foster self-direction and self-advocacy on the part of clients. These program elements include staffing, geographical location of the program and its environment, program content and structure, and training of clients and staff.

Recommended Action

1. Short Term (one year)

- A. Several factors can have a vital impact on a client's self-image and his/her growth in self-direction and self-advocacy skills.

- (1) Direct service staff in both residential and day programs can either foster or impede a client's exercise of self-advocacy and growth in independence by its attitudes and day-to-day interaction with developmentally disabled individuals.
- (2) The location of alternate living arrangements and day program sites away from the mainstream of the community can preclude normalizing experiences, such as walking to shop or work or using public transportation and other community resources. The location of day training centers apart from other educational programs does not provide normalizing experiences for children.
- (3) The environment within program sites can reflect societal attitudes toward developmentally disabled persons, which often include imagery of them in a perpetual child-like state. These attitudes in turn are internalized by developmentally disabled individuals and constitute a barrier to self-direction and continued growth. Adornments such as cartoon characters that are totally not age-appropriate exemplify this problem.

The task force recommends a study of the above factors and their effect on client self-direction. The report resulting from this study should incorporate specific recommendations in terms of creating conditions that promote rather than impede independence. (The report should be completed by June 30, 1987.)

- B. The task force recommends the development (by May 31, 1987) of a training module with specific content for
 - (1) Training clients in self-advocacy skills. One important aspect of this training should focus on client participation in the development or review of the IHP or other program plan.
 - (2) Orienting and training staff, group home and skill development home providers, etc., regarding the principles of self-advocacy as well as techniques and strategies that effectively direct clients toward increasing independence and self-advocacy skills.
 - (3) Orienting and training parents and siblings in principles of self-advocacy and fostering self-advocacy skills in their developmentally disabled family members.

This training recommendation should be seen as addressing three aspects (clients, parents, and staff) that are intrinsically correlative and mutually complementary.

- C. The task force recommends examination of current policies and regulations in community residential programs, with an eye toward their individualization. Blanket policies designed for the safety of residents may be overly restrictive for more capable individuals. Policies governing sexual relationships, access to one's home, room inspections, schedules for meals and bathing, choice of activities, curfew and bedtime hours, and use of telephones are among the issues recommended for scrutiny in light of maximum development of each resident's self-direction.
- D. When new community residential models are being considered for the population to be served by DDD, information from new clients with residential needs should be solicited to obtain their ideas for an optimum living situation allowing the greatest independence.
- E. The task force recommends the inclusion of at least one developmentally disabled consumer on advisory and policy-making boards of state agencies and private provider agencies under contract with DDD.
- F. An exploration of alternative work or pre-work training is recommended. Currently much of the training for work skills centers around crafts and piecework that is done through repetitive steps and requires that the trainee be sedentary or stationary. Doing such work may not be possible for many clients with autism or cerebral palsy and may

not allow for the optimum development of work skills and behaviors among many of those who are mentally retarded or epileptic. Exploration of on-site job training and projects, e.g., horticulture, maintenance, and recycling, that utilize gross motor skills is recommended. In this process, information from clients in terms of self-advocacy should be considered essential. In the same context, the developmentally disabled person's right to "retirement" at a certain age should be recognized.

2. Long Term

- A. Have in place ongoing self-direction and self-advocacy training for all clients, staff, parents, and siblings.
- B. Have underway enactment of the recommendations from the study on the effects of staff, program location, and environmental factors on client autonomy.
- C. Have in place alternative work, pre-work, and other programs geared to the interests and abilities of the disabled population.

HOUSING TASK FORCE

Task Force Charge

The Housing Task Force was charged explicitly with the responsibility for researching the housing needs of non-mentally-retarded, developmentally disabled individuals and with making recommendations for developing appropriate housing for this group. Implicit in the task force charge was the expectation that the Division of Developmental Disabilities (DDD) will continue to develop community-based housing for its mentally retarded clients, as detailed in the DDD planning documents: *Phase Two* and *The Equity Plan*.

Introduction

The recommendations of the Housing Task Force should result in new housing initiatives for a previously unserved group—the non-mentally-retarded, developmentally disabled population. Resources required for implementation of the recommendations should be specifically requested by DDD and should be in addition to those resources already identified as necessary for the continuation and expansion of services for mentally retarded individuals.

Persons with developmental disabilities, whether or not they are mentally retarded, may appropriately live in any of several housing options. (See Appendix I, Housing.) However, persons with developmental disabilities have various housing needs, and if they are to maximize their independence, they will require assistance with gaining access to the most appropriate and least restrictive housing option for each person.

Issue Statement: Housing Needs

The difference between the housing needs of the non-mentally-retarded, developmentally disabled person and those of the mentally retarded person is not the type of housing, but rather the type and amount of assistance required to support each client in his/her most appropriate living arrangement.

Statement of Need

The service models used by DDD for its mentally retarded clients in need of alternative living arrangements do not adequately meet the needs of developmentally disabled persons who are not retarded. Therefore, new service models must be developed. Common barriers to independent living for the disabled are (1) physical inaccessibility of housing and (2) inadequate financial and/or support service assistance.

Recommended Action

1. DDD should provide additional barrier-free housing units, assist clients with gaining access to existing units that are not being used by developmentally disabled persons, and be prepared to provide funding for minor renovations that will make an individual's own home more accessible.

- A. Improving accessibility may include kitchen and bathroom modifications, alterations of doorways, and the addition of ramps and specialized equipment. The Housing Task Force's subcommittee is responsible for drafting the justification for a capital appropriation to provide funding for accessibility alterations. The subcommittee report will be completed by September 1, 1986.
- B. DDD will establish single-family dwellings (classified as R-3 Use Group) to house no less than two persons who are non-ambulatory. At least one dwelling will be established in FY1987.
- C. DDD will develop an agreement with the Division of Housing in the Department of Community Affairs (DCA) to ensure that DDD clients will have equal access to Section 8 rental certificates. A draft of this agreement will be ready for presentation to DCA by June 30, 1986.
- D. DDD will name a person in each region to assist clients with gaining access to various housing options, develop a county-based resource directory, expedite access to Section 8 rental certificates, and develop networks with the following and other groups:

Community Development Office
New Jersey Mortgage Financing Agency
Human Services Advisory Council
Office(s) of the Handicapped
County Welfare Agencies

The Community Services staff will identify each person by title by June 30, 1986.

- E. To facilitate the adoption process, DDD should consider the possibility of providing adequate funds for making accessible to developmentally disabled persons the homes of those individuals who are initiating special needs adoption procedures. This step should be activated in FY1988.
 - F. DDD should consider assisting skill development sponsors with making their homes accessible to non-ambulatory adults. This step should be activated in FY1988.
2. Based on the needs of developmentally disabled persons that were identified by the DDD regional staff, specific housing-related projects should be named by DDD for funding in its future budget requests. The budget items should be targeted for particular non-mentally-retarded, developmentally disabled groups and should be over and above the funding levels needed for providing adequate services for mentally retarded persons. Because non-mentally-retarded, developmentally disabled individuals may have some capacity for self-direction and may be able to participate financially toward their own support, funding arrangements should include the possibility of direct client participation.
- A. Because non-mentally-retarded, developmentally disabled individuals not only have the right to participate in the choice and financing of their housing arrangements but are also responsible for doing so, DDD will provide supportive services to permit full exercise of this responsibility. These services will begin in FY1989 and will include
 - (1) Direct rent subsidy with an upper limit based on a schedule, e.g., the fair market rent established by Housing and Urban Development (HUD). The participant will be expected to contribute up to thirty per cent of his/her personal income, with the understanding that in some circumstances (e.g., when medical expenses are extraordinary) the contribution may be less than thirty per cent.
 - (2) Money for start-up needs (utility and rent deposits, furnishings, and household goods).
 - (3) Evaluation of therapeutic needs, training, and assistance with obtaining adaptive equipment needed by a client to permit his/her access to fully independent living.

- B. When other funds are not available, DDD will provide the assistance necessary to preserve and maintain an individual in his/her natural setting. Assistance will begin in FY1988. Action to provide this assistance will include but not be limited to expanding the funding for home assistance and supportive living to cover the non-mentally-retarded DDD clients.
- C. DDD will identify specific funding to provide accessible group homes and apartments for non-mentally-retarded, developmentally disabled clients. This funding will begin in FY1987.
- D. DDD will continue its current efforts to provide housing for specific groups, such as autistic persons.
- E. DDD will encourage broader use of Department of Human Services capital funding for new construction by considering
 - (1) The removal of costly barriers, e.g., the current construction bonding requirements
 - (2) The establishment of a revolving fund for capital construction whereby rent monies will be used for mortgage payments

The Program Development Unit will issue a report on its findings by December 31, 1986.

- 3. The objective for all developmentally disabled persons should be their achieving their maximum potential independence. The Housing Task Force realizes that this may mean the provision of flexible comprehensive treatment programs within the housing program for some of the more severely handicapped, developmentally disabled individuals.

Specialized core-related services can be provided within a non-medical, personalized environment. Such programs will provide individualized skill development training and other core services, including but not limited to nursing and medical care and occupational, physical, and speech therapy. Supplemental services will be provided as needed and may include psychological, psychiatric, neurological, and urological care. All services will be individualized and provided on an as-needed basis.

Services may be necessary for a short-term evaluation and/or stabilization of an individual's condition. Long-term services may be necessary to meet ongoing needs and to provide the support required if an individual is to continue his/her growth and development.

- 4. DDD should review alternative living facilities and programs to determine whether licensing is appropriate. The Housing Task Force appointed a subcommittee to recommend alternatives to licensing by September 1, 1986.
 - A. All facilities selected by DDD (or an agency under contract with DDD) to provide residences for clients whose residence contracts include funding must be licensed. However, this does not mean that the home of a client receiving rental assistance must be licensed.
 - B. DDD will establish an ongoing committee to review DDD licensing standards. This committee will include consumers and providers and will recommend changes based in part on requests for variances or waivers. The implementation of changes in licensing standards will occur as needed, but at least once every five years.

TRANSPORTATION TASK FORCE

Task Force Charge

The Transportation Task Force was charged with studying the transportation needs of non-mentally-retarded, developmentally disabled individuals, the existing resources that might meet those needs, and the current gaps in transportation services for persons with developmental disabilities.

Introduction

The task force identified many unmet transportation needs, mainly through its survey of the sixty-three groups who serve New Jersey's disabled population. Common problems reported by the thirty-three groups who responded include

1. Lack of affordable transportation for competitively employed individuals
2. Insufficient access to public transportation, especially in southern New Jersey
3. Little or no evening, early morning, and/or week-end service
4. Inadequate accommodations for non-ambulatory individuals
5. Lack of services for community outings (e.g., recreation and shopping)

The task force also found that the existing network of specialized transportation resources throughout the state is extensive and includes the following and many other resources designed to increase the mobility of disabled individuals:

1. Handicapped-accessible public transportation
2. Local paratransit systems
3. Specialized vehicles operated by public and private agencies, including the 407 vehicles (listed in Appendix II, Transportation) operated by the Division of Developmental Disabilities (DDD)
4. Commercial vehicles (e.g., taxis and ambulances)
5. Volunteer transit-assistance programs

This network is growing continually and is aided significantly by funds awarded through the state Senior Citizen and Disabled Resident Transportation Assistance Act, a 1984 law dedicating seven and one-half per cent of each year's casino revenues to upgrading transportation for senior citizens and the disabled. Seventy-five per cent of the funds is distributed among the state's twenty-one counties, and the remainder goes to New Jersey Transit. In 1985 alone, the funds totaled ten million dollars. Consequently, each county is either establishing or expanding its specialized transportation system. New Jersey Transit, which administers the project, is using its funds to buy additional handicapped-accessible buses (for a total of six hundred buses by December 1986), give instructions in their use, develop a special training program for bus drivers, and renovate many of its bus and train stations to make them accessible to disabled riders.

Much of this resource network is currently underused. However, several of its principal contributors have offered to work cooperatively with DDD to meet the transportation needs of division clients and to avoid duplication of services. DDD was asked to help form an interagency committee on transportation for disabled persons. In addition, several transportation agencies have offered to incorporate information about the needs of DDD clients into their planning processes.

The following recommendations are based on the premise that the existing transportation network should be used to serve division clients wherever possible and practical and should be expanded or modified as needed through the cooperative efforts of DDD and other components at the state and local levels.

Issue Statement: Transportation Network

Individuals with developmental disabilities, like other citizens, are entitled to educational and vocational opportunities, recreational and social activities, health care, and other necessities. Access to these services greatly depends on the availability of appropriate transportation. In addition, as more developmentally disabled adults attempt to establish independent lives and as they continue to move toward normal living and working arrangements, they will need a more extensive, diverse, and innovative transportation network. Although DDD is not equipped to meet all client transportation needs, it should be prepared to direct clients to appropriate services, advocate for better transportation for disabled individuals, and where possible, provide transportation for those clients who cannot obtain it elsewhere.

Statement of Need

The basic transportation needs of many developmentally disabled individuals are not being met. This apparently is attributable to a number of factors, e.g., incomplete information about the needs of these individuals, lack of available services, and insufficient information about existing transportation services. Since the needs of disabled riders and the resources available to meet those needs vary widely throughout the state, identifying unserved populations and remedying gaps in services must be done largely on a county-by-county basis.

Recommended Action

1. Hire a transportation project director by December 31, 1986. His/her duties will include the following:
 - A. Acting as transportation liaison to state agencies and statewide non-profit agencies serving the developmentally disabled population and representing DDD on related committees, projects, and activities
 - B. Coordinating activities of regional transportation liaisons
 - C. Developing and maintaining transportation resource information (e.g., the annual directory and/or statewide information and referral system)
 - D. Identifying, with the help of regional liaisons, the transportation needs of clients admitted to DDD services
 - E. Promoting involvement of state agencies, the business community, and the general public in meeting the transportation needs of developmentally disabled individuals
 - F. Identifying and/or developing transportation alternatives (e.g., shared-ride taxis, car-pools, and volunteer drivers) to supplement use of special vehicles
 - G. Investigating possible sources of outside funding (e.g., other state agencies and the Developmental Disabilities Council) for special transportation projects
 - H. Working cooperatively with the central office staff (e.g., employment, housing, training, and community education staffs) to address the transportation needs of clients

A core group within the Transportation Task Force agreed to take responsibility for compiling resource information, maintaining contacts with outside agencies, and assisting

in the development of the transportation needs questionnaire, pending the hiring of the proposed transportation project director.

2. During the first six months of the project director's tenure, hire a transportation liaison for each region. His/her principal duties will include the following:
 - A. Acting as transportation liaison to local government offices and non-profit organizations serving developmentally disabled persons and representing DDD local committees, projects, and activities related to transportation
 - B. Assisting in the development and maintenance of DDD's transportation resource information
 - C. Recruiting volunteers within the region to assist in transporting developmentally disabled individuals
 - D. Developing transportation alternatives for disabled persons in cooperation with local organizations, government offices, and providers
 - E. Working cooperatively with regional staff to address the transportation needs of clients
3. Conduct a transportation needs survey and a resource inventory of transportation services and initiatives throughout the state—including county programs, sheltered workshops, and agencies serving developmentally disabled individuals.

The task force has initiated these surveys and is compiling the responses in a resource report. This document, although incomplete, is already serving as a source for information and referrals. In addition, the task force surveyed eleven neighboring states to learn about their procedures, policies, and initiatives for specialized transportation. Eight states responded and indicated that they are involved in or exploring special transportation services for disabled riders—some directly and others through providers.

4. Identify transportation needs and capabilities as an initial step in the assessment of each individual admitted for DDD services. A needs questionnaire should be developed by Community Services staff by December 1986 and should be administered to each client following confirmation of his/her eligibility.
5. Publish a statewide resource directory including
 - A. Available transportation services
 - B. Avenues for special assistance
 - C. Transportation-related discounts and incentive programs
 - D. Information about regulations for issuance of drivers' licenses to disabled individuals
 - E. Consumer information about adaptive equipment for cars and vans
 - F. Telephone numbers for transportation-related programs, agencies, and businesses throughout the state

This directory should be developed in early 1987.

6. Assign to DDD transportation training staff the responsibility for a study to determine what type of training is needed by transportation personnel (in public and private systems) to enable them to assist developmentally disabled riders. This study should be followed by a review of existing training programs, e.g., Passenger Assistance Training and New Jersey Transit's Elderly and Handicapped Sensitivity Training. Information on these programs should be collected by training and transportation staffs. Both activities should be completed by December 31, 1987.
7. Establish by June 1987 a set of procedures for identifying and processing priority transportation requests (transportation to obtain medical care, commuting to competitive employment, etc.).

(See Appendix I, Transportation, for the long-range transportation staffing plan designed by the DDD executive staff in response to these recommendations.)

Issue Statement (See above.)

Statement of Need

The number of developmentally disabled individuals residing in the community will increase in the coming years. Disabled persons have a wide range of abilities and consequently will have a wide variety of transportation needs. Those needs will be more diversified as disabled individuals join the competitive work force, develop more social and recreational interests, and take better advantage of community resources. Therefore, the transportation resource network must be expanded and made flexible enough to accommodate and meet the ever-changing needs of a larger and more heterogeneous ridership.

Recommended Action

1. Continue and strengthen the working relationships that the task force has initiated with state and county agencies involved in the transportation of disabled individuals and promote the involvement of other groups (e.g., service organizations and the business community) in meeting the transportation needs of this population. Interagency relationships should ultimately include a state-level committee to facilitate information sharing and cooperative surveying and planning efforts, as well as agreements to share or consolidate transportation services.
2. Support the appropriate use of public transportation by developmentally disabled individuals by
 - A. Providing information about the locations of accessible bus and train stations, lift-equipped public vehicles, and accessible bus routes
 - B. Arranging (in cooperation with New Jersey Transit's Project Access) demonstrations of wheelchair lifts and slide-show presentations on the use of lift and kneeling buses
3. Investigate transportation alternatives that might expand or supplement the use of special vehicles. (This investigation is currently being done.) By December 1987, initiate at least one demonstration project for alternative transportation. Options to be studied should include
 - A. Shared-ride taxi services
 - B. Car-pooling networks among disabled and non-disabled co-workers
 - C. Extended and/or shared use of agency vehicles
 - D. Paid or volunteer escorts to assist disabled individuals in getting from bus and/or train stations to their destinations
 - E. Volunteer drivers who can use their cars to transport disabled riders
 - F. Further use of DDD's in-house transportation system
4. Establish a statewide information and referral system for obtaining transportation for disabled individuals. As an initial step, DDD should meet with representatives of other state agencies to determine whether establishing this system should be a cooperative venture.

Future Task Force Activities

In addition to carrying out the responsibilities outlined in this report, members of the task force's core work group will further investigate the possibility of conducting a demonstration project for alternative transportation and will submit at least one pilot proposal by September 1986. This will be done in response to the Project Redirection Advisory Committee's request for a more specific pilot recommendation.

Stage II of Project Redirection was discussed at the task force's meeting on April 10, 1986. Members recommended the selection of one representative from the Transportation Task Force to serve on the Stage II steering committee.

RECODIFICATION TASK FORCE

Task Force Charge

To analyze the impact of the Developmental Disabilities Act on existing statutes, administrative codes, division circulars, policies, and procedures.

The task force will recommend the necessary changes in all statutory and administrative materials to the Project Redirection Advisory Committee.

Introduction

The Division of Developmental Disabilities (DDD) operates within a legal and procedural framework established in state laws, regulations included in the New Jersey Administrative Code, Department of Human Services administrative orders, DDD circulars, and agreements that the division has with other public and private agencies. These documents delineate the division's authority and responsibilities, clients' rights, and minimum standards for services provided by DDD.

The service needs of persons with other developmental disabilities are different from the needs of those with mental retardation. Therefore, a review of legal and procedural documents was essential to ensure that the framework set for DDD appropriately supported service delivery to persons with developmental disabilities.

Issue Statement: New Jersey Statutes, Title 30

Title 30 includes sections that establish the Department of Human Services (DHS) and detail its authority and responsibilities. A few recent sections apply to all persons with developmental disabilities (e.g., 30:6D, The Developmentally Disabled Rights Act, and 30:11B, Community Residence for the Developmentally Disabled). However, several sections apply only to mentally retarded persons. Title 30 needs to be amended to clarify the scope of services for persons with developmental disabilities.

Statement of Need

Although the Division of Developmental Disabilities Act (DDD Act) amends certain sections of Title 30 to ensure consistency with the act, it leaves unchanged other critical sections. These unchanged sections identify specific requirements for services for mentally retarded persons that are not included in the DDD Act (e.g., notification of eligibility for services and DHS's responsibility for providing for the health and safety of clients). These sections need to be amended to clarify that

1. DHS's clearly delineated authority over functional services for mentally retarded persons is extended to developmentally disabled persons
2. Developmentally disabled persons are provided the same rights and safeguards as mentally retarded persons, as they go through the application and service delivery system

Recommended Action

1. Short Term (one year)

- A. Emphasis should be on revising existing regulations in the New Jersey Administrative Code (NJAC) as an initial method for establishing DDD's responsibilities and authority in regard to services for developmentally disabled persons. (See this report's section on regulations.)
- B. Although this task force does not expect that the final recommendations of the Intake/Eligibility Task Force will require revision of Title 30, DDD's administrative practice officer should review those recommendations within ninety days of their acceptance by the DDD director. The administrative practice officer may refer the recommendations to the Recodification Task Force for review, if he/she deems it necessary.
- C. This task force does not expect that the recommendations of the Housing Task Force or its subcommittee on licensing will require revision of Title 30. However, DDD's administrative practice officer should review those recommendations within ninety days of their acceptance by the DDD director. The administrative practice officer may refer the recommendations to the Recodification Task Force for review, if he/she deems it necessary.
- D. The Recodification Task Force will make recommendations for revisions to Title 30 by June 30, 1986.

2. Long Term

DDD, through its director's executive assistant, should submit to DHS its recommendations for changes in Title 30 by December 31, 1986.

Issue statement: New Jersey Statutes, Other Than Title 30

The section of the statutes that has the most direct impact on developmentally disabled persons is Title 30. However, there are other sections (e.g., insurance laws) that have an impact on persons with mental retardation, physical and mental incapacity, etc.

Statement of Need

A preliminary review of a word search of sections of the statutes other than Title 30 identified a few sections that may need to be revised. These sections currently apply to mentally retarded or mentally and physically disabled persons but may be applicable to all developmentally disabled persons. A more in-depth review needs to be completed to determine whether revisions have to be made to these sections.

Recommended Action

1. Short Term (one year)

- The Recodification Task Force will further evaluate the sections of the statutes other than Title 30 and identify by May 1, 1986, those sections that should be revised to ensure that appropriate legal safeguards currently in place for mentally retarded and other disabled persons are extended to all developmentally disabled persons. (The evaluation and identification has been completed.)
- B. The Recodification Task Force will make recommendations for revisions to sections of the statutes other than Title 30 by June 30, 1986.

2. Long Term

DDD, through its director's executive assistant, should work with DHS, the Developmental Disabilities Council, and other relevant agencies to develop strategies to bring about necessary changes in statutes affecting other state departments.

Issue Statement: Regulations (New Jersey Administrative Code)

DDD has nine regulations published in the New Jersey Administrative Code (NJAC). All of these refer to DDD as the Division of Mental Retardation (DMR). Four of the regulations involve housing (institutional and community-based). The effect of the DDD Act on these housing regulations will be clearer after the recommendations of the Housing Task Force have been formalized. One of the regulations delineates eligibility criteria, which are being evaluated by the Intake/Eligibility Task Force. Two of these regulations will be revised to concur with the new guardianship law. These regulations need to be amended to clarify DDD's role in regard to services for developmentally disabled persons.

Statement of Need

All of DDD's regulations need to be revised to reflect the changing of the division's name. Regulations for eligibility for services and for community-based residences need to be revised to reflect the recommendations of the task forces reviewing these areas. NJAC 10:40, which states the goals of the division, needs to be revised to reflect DDD's new role. The regulations for determination of mental deficiency and guardianship services need to be revised to reflect the requirements of the new guardianship law, which established a procedure that is more appropriate for developmentally disabled persons than the previous procedures.

Recommended Action

1. Short Term (one year)

- A. Proposed revisions to NJAC 10:43, Determination of Mental Deficiency, and NJAC 10:45, Guardianship Services, reflecting the requirements of the new guardianship law should be submitted by July 1, 1986, to the DDD director by the division's administrative practice officer.
- B. NJAC 10:40, Organizational Rule, should be revised by the division's administrative practice officer to reflect the goals of DDD in its new role and adopted by September 1, 1986.

2. Long Term

- A. Based on the recommendations of the Housing Task Force's subcommittee on licensing, DDD's Office of Licensing and Inspection should review NJAC 10:44A and 10:44B, which delineate standards for community-based residential programs, to determine whether revisions need to be made or additional regulations developed to accommodate housing alternatives for developmentally disabled persons. Proposed revisions or new regulations should be submitted to the DDD director by March 31, 1987.
- B. NJAC 10:46, Application and Admission to Functional Services, should be revised in coordination with the administrative practice officer, following acceptance of the Intake/Eligibility Task Force's final recommendations. The effective date for the revised regulation identifying changes in eligibility criteria should be March 1, 1988, to allow for adequate resources to be in place to serve the additional developmentally disabled persons who will be eligible for services.

- C. NJAC 10:44 and 10:47, which delineate standards for public and private institutions, should be reviewed by DDD's Office of Residential Services during calendar year 1989 for possible revisions based on changes in the division's role.

Issue Statement: Administrative Orders

DHS administrative orders that delineate operational policies for the department generally do not identify specific divisions by name. However, there are eleven administrative orders that specifically refer to the Division of Mental Retardation.

Statement of Need

The vast majority of changes that need to be made in administrative orders involve changing the name of the division and do not have an impact on divisional or departmental operations. However, two administrative orders may require changes to ensure that the procedures involved are applied to eligible developmentally disabled persons.

Recommended Action

Short Term

A report on the task force's review of administrative orders has been forwarded to the DHS Policy and Procedure Unit. This report identifies the administrative orders affected and recommends changes.

Issue Statement: Division Circulars

Division circulars provide a system for disseminating divisional policies and procedures to components of DDD and service providers regulated by and/or under contract with DDD. Circulars must be reviewed every two years and necessary revisions made. DDD's Policy and Procedure Committee is currently updating circulars and recent issues show the change in the division's name and role. However, most of the existing circulars were issued prior to the Division of Developmental Disabilities Act and need to be revised to reflect this change.

Statement of Need

Although the content of most of the DDD circulars is not affected, many of the circulars need to be revised to reflect the name change of the division. A few circulars require substantive changes to reflect the division's role in providing services for developmentally disabled persons. Some of the circulars that require substantive changes detail in circular form the policies and procedures delineated in administrative code regulations (e.g., guardianship and goals of the division), and revisions to these circulars need to follow the revisions in the regulations.

Recommended Action

1. Short Term (one year)

The Recodification Task Force has submitted to DDD's Policy and Procedure Committee the recommended revisions in division circulars requiring substantive changes.

2. Long Term

- A. Division circulars for guardianship and goals of the division should be issued by the DDD director in revised form within ninety days of the adoption of the corresponding regulations.
- B. The division circular that includes eligibility criteria should be issued in revised form by the DDD director within ninety days of his/her acceptance of the final recommendations of the Intake/Eligibility Task Force.
- C. Division circulars that do not require substantive changes should be revised, in accordance with DDD's two-year mandated review system, to reflect the change in the division's name.

Issue Statement: Interagency Agreements

DDD has entered into agreements with other divisions within DHS and other departments, with counties, and with private agencies. A preliminary review of these agreements indicates that the content of most does not require revision. However, some apparently will need revision based on the changes in eligibility criteria, and some may be affected by the recommendations of the Housing Task Force.

Statement of Need

Existing interagency agreements need to be reviewed in greater detail to determine the impact made on them by the change to Division of Developmental Disabilities.

Recommended Action

1. Short Term (one year)

- A. Existing interagency agreements should be reviewed by the divisional components involved in the agreements to determine whether any changes are needed to reflect the provision of services for developmentally disabled persons. The involved components should forward their recommendations for revisions of the agreements to the Recodification Task Force by May 1, 1986. (This has been done.)
- B. The Recodification Task Force will review the recommendations of the divisional components and make final recommendations to the DDD director by August 1, 1986.
- C. Those interagency agreements identifying DDD as the Division of Mental Retardation, but not requiring substantive changes, do not require revision at this time.

2. Long Term

- A. Copies of all interagency agreements should be maintained by DDD's administrative practice officer to ensure consistency and easy availability of all interagency agreements to which the division is a party.
- B. DDD's administrative practice officer should review methods for disseminating the information included in interagency agreements to relevant divisional components and should report his/her findings to the DDD director by December 1, 1986.
- C. DDD's administrative practice officer should review methods for reviewing existing interagency agreements and implementing the requirements of those agreements. Consideration should be given to the regular review of agreements and assignment of expiration dates. The administrative practice officer should report his/her findings to the DDD director by December 1, 1986.

MENTAL HEALTH/DEVELOPMENTAL DISABILITIES TASK FORCE

Task Force Charge

To evaluate the access to community mental health programs that is currently available to individuals with developmental disabilities. The survey of service needs completed by the Mental Health/Developmental Disabilities Task Force will be used in the assessment of community programs.

The task force will recommend strategies for service use and joint program development to the Project Redirection Advisory Committee.

Introduction

Developmentally disabled individuals with mental health problems have not, in the past, been adequately or appropriately served within New Jersey's human services delivery system. As the distinct needs of this population have become more clearly defined within the professional community during the last twenty years, efforts have been made on a state level, by means of broad policy statements, to address the need for improving program delivery. In recent years, top-level administrators at the Division of Mental Health and Hospitals (DMH&H) and the former Division of Mental Retardation (DMR), which is now the Division of Developmental Disabilities (DDD), have acknowledged the need for interagency cooperation and have endorsed a number of task force efforts.

In fall 1984, the Developmental Disabilities Council (DDC) convened the Task Force on Crisis Prevention and Intervention for Persons with Developmental Disabilities in Group Homes. The task force's charge was to review the need for crisis prevention and intervention services for developmentally disabled individuals in group home settings, assess state-of-the-art program models, and recommend program development. Its final report was issued in June 1985.

With the implementation of S. 1826 (The Division of Developmental Disabilities Act) passed in April 1985, a significant number of diverse developmentally disabled New Jersey citizens will become eligible for DDD services and programs. As part of Project Redirection, the Mental Health/Developmental Disabilities Task Force was formed and charged with studying the access to community mental health programs that is currently available to developmentally disabled individuals living in a variety of community arrangements. Although the focus of the latter task force differed significantly from that of the former, the work of the Project Redirection group was expected to build on that of the first group.

In addition to incorporating the efforts of the previous task force into its work, the Mental Health/Developmental Disabilities Task Force served as a setting in which representatives from DDD and DMH&H could effectively plan interagency programs to meet the needs of the developmentally disabled population. During the time that the task force met, a number of new cooperative interagency initiatives occurred throughout the state. Most importantly, key administrative representatives from DDD and DMH&H gained a greater understanding of one another's systems and significantly improved communication between the divisions. The task force hopes that this dialogue will continue between the division staffs on central and regional office levels.

Issue Statement

Persons with developmental disabilities have mental health needs that are not adequately or systematically met by the services currently available through DDD and DMH&H. Providers of these services lack sufficient knowledge about the unique problems and concerns of persons with developmental disabilities.

Statement of Need

Persons with developmental disabilities experience not only mental health problems similar to those of persons in the general community but also problems that pose a risk for them in particular due to their disabilities. Therefore, it is critical that DDD and DMH&H develop a continuum of coordinated generic services, with corresponding training components, to make the full range of mental health services accessible to all persons with developmental disabilities. The emphasis in program development should be on generic services based on clients' functional rather than diagnostic definitions. This approach will help to prevent a repetition of past situations where many developmentally disabled persons who had mental health problems were frequently labeled *dually diagnosed* and thus either inappropriately or inadequately served.

Results of survey questionnaires distributed to diverse provider agencies in both divisions and an informal survey of county Human Services representatives confirm that the need for generic services has not been met. In addition, the Epilepsy Foundation of New Jersey conducted an extensive needs assessment with one component specifically addressing mental health issues. The results from this study show similar service gaps for persons with epilepsy. Appendixes I and II, Mental Health, describe the DDD and DMH&H survey results.

Recommended Action: Strategic Planning

1. Central Office Level

The central offices of DDD and DMH&H should provide leadership for and actively support the development of a broad continuum of mental health services for developmentally disabled persons. To accomplish this goal, DDD and DMH&H need to work systematically and cooperatively to develop a coordinated mental health service system.

An important starting point for this planning is a demographic analysis of the disabled population, which should focus on the total potential population—institutional and community-based. The completion of the analysis should be coordinated by both divisions so that profiles of the targeted population will be consistent. This task force conducted surveys on a small scale, and although limited in scope, the surveys presented interesting findings that should be further developed for use in the responsible planning of services for disabled clients. The task force found it particularly significant that issues related to family support emerged as a high priority and concluded that a more in-depth investigation should be done of the specific types of family support needed, to determine whether these services should be provided by agencies currently serving developmentally disabled persons or whether new delivery models should be developed.

Planning efforts should be coordinated by the DDD Office of Community or Residential Services (as appropriate) and the DMH&H Office of Planning.

2. Regional Office Level

The goal of the corresponding regional component of this planning process will be to communicate the priorities for services identified by DDD and DMH&H to regional and county offices. The first step will be the establishment of reciprocal DDD and DMH&H representation on specific county planning bodies. One way in which this has already been

done is through the Human Services Advisory Councils established by the Department of Human Services (DHS) in each county. (Human Services Advisory Councils coordinate all human services within a county.)

Within the mental health system, a county mental health board exists in each county catchment area. The county mental health board decides how the state community mental health priorities are to be translated into local action.

The advisory councils and the county mental health boards play important roles in the planning of mental health services for the general community. The DDD mental health coordinator (see below for job description) will be required to serve on these two county planning bodies.

Correspondingly, there must be DMH&H representation on the DDD county and regional levels. Since similar local planning bodies do not currently exist in the DDD structure, the task force recommends that DDD regional administrators begin to develop local mechanisms through which DMH&H can gain involvement in DDD local planning efforts. One option may be to develop county advisory boards (with similar compositions to the county mental health boards) on which DMH&H regional coordinators can serve.

Through this representation several purposes in the planning process will be served. Local planning bodies will be sensitized to the mental health needs of those persons with developmental disabilities who reside in their communities. DDD Community Services staff will be provided with a point of intervention whereby it can influence the systems that provide services to this population. And this representation will be a means by which DDD and DMH&H policies and priorities can be made available to county advisory boards for consideration in their planning process.

As a second step, local planning bodies, with their increased sensitivity to the needs of developmentally disabled persons, should transmit the needs they have identified on the local level to the state level so that their work will have an influence on the over-all state planning process of DDD and DMH&H. This can most effectively be accomplished by the division representatives who are serving on the local boards and advisory councils.

Recommended Action: Division of Developmental Disabilities Mental Health Coordinators

Integral to the success of this strategic planning will be the creation of four DDD regional mental health coordinator staff positions by FY1987. Regional mental health coordinators will be responsible for the following:

1. Serving as liaisons with DMH&H on local levels, i.e., with regional coordinators
2. Serving on community health boards and DHS advisory councils and transmitting recommendations to the DDD central office to influence statewide planning
3. Assisting in the development of training programs on developmental disabilities for DMH&H provider agencies
4. Providing technical assistance and resource information to DMH&H and DDD provider agencies regarding mental health issues of the developmentally disabled population
5. Developing a county and regional resource directory of mental health facilities and services that are adequately serving persons with developmental disabilities
6. Maintaining current copies of affiliation agreements in DDD and DMH&H provider agencies
7. Serving as consultants to DDD case management staff for problem admissions or discharges of clients moving to or from residential psychiatric facilities or community mental health agencies

If the coordinators are to have a significant impact in carrying out these responsibilities, their positions must be set at a significantly high level of authority and responsibility within DDD and at a correspondingly high salary level.

In addition, the task force recognizes the inherent difficulty these staff members will meet when trying to effectively interface with the DMH&H service delivery system since it is structured very differently from that of DDD. The task force hopes that the definition of this position as a highly responsible one within DDD and the development of close working relationships between DDD and DMH&H staffs will help to significantly improve the delivery of mental health services to persons with developmental disabilities.

Specific Recommendations

1. Central Office Level

A. Training

A systematic training program covering a wide variety of topics relative to the developmentally disabled population with mental health concerns is needed for all DDD, DMH&H, and provider agency staffs. This training program should be coordinated by DDD and DMH&H directors of training programs, with regional assistance from DDD's mental health coordinators and DMH&H's regional coordinators.

(1) Emergency and crisis intervention curriculum

Consistent with its goal to build a continuum of services, this task force supports the current development of the emergency and crisis intervention curriculum as a first step in the training process. An advisory committee was formed at DMH&H, with representation from DDD, to assist in the development of this curriculum.

The module focuses primarily on a generic type of assessment and is adaptable to specific populations, such as children or persons who are developmentally disabled or elderly. It was offered as a pilot in Atlantic, Mercer, Middlesex, and Passaic counties in June 1986 and administered to crisis workers in DMH&H provider agencies. During the next eighteen months, DMH&H plans to certify crisis screeners when they complete this training.

A long-range goal, in the implementation of this curriculum, is to work with the Rutgers University Sociology Department to develop a graduate course using the curriculum's content. The course will be multi-disciplinary and will be open to graduate students in all mental health fields. (Topics included in this curriculum are listed in Appendix III, Mental Health.)

(2) Additional joint training programs

Additional joint training programs should gradually be made available to staffs at all DDD and DMH&H facilities providing this continuum of services. After the emergency and crisis intervention curriculum has been administered and evaluated, the possibility of adapting it for use in DDD community-based settings should be explored. With additional information from knowledgeable DMH&H personnel, a training model can be developed to emphasize the mental health needs of developmentally disabled clients in community settings and teach workers how to appropriately identify mental health crises.

Thorough training of DDD case managers is clearly needed to increase their knowledge of clients' mental health needs and to improve their ability to effectively gain access to community resources. Additional case managers are also critically needed. The task force supports the recommendation of its predecessor, the Task Force on Crisis Prevention and Intervention for Persons with Developmental Dis-

Homes, in regard to the need for more case managers and suggests that resources should be allocated toward developing additional training programs only if the programs are developed in conjunction with the creation of additional case management positions. This dual commitment is necessary if training programs are to be effective.

(3) Conference on medication, education, and adherence

An initial conference on medication, education, and adherence, planned by DMH&H, was held on April 10, 1986. The conference aimed at clarifying values, fostering a cooperative problem-solving attitude, and sharing information regarding some of the more innovative and effective approaches to the mental health problems of individuals with developmental disabilities. DDD staff attended this conference.

(4) Physician training

A similar training need exists for physicians completing their psychiatric training at the University of Medicine and Dentistry of New Jersey—Robert Wood Johnson Medical School. In response to this need, the task force recommends that the UAF, by means of its pre-service training program, develop and coordinate a training module.

B. Affiliation agreements

To ensure that persons with developmental disabilities have entry to the generic mental health system, and particularly to crisis services, the task force recommends the negotiation of agreements between the facilities performing the initial emergency/crisis screening in each county and the service components of DDD. These agreements will include the contracted group home and day program providers, state-operated day programs, and the regional offices serving developmentally disabled clients living in their own homes or in skill development and family care homes.

The agreements will stipulate that all eligible developmentally disabled individuals should be served and that emergency service workers should receive training in handling developmentally disabled persons in crises. The agreements will also specify the appropriate procedures to follow with clients, e.g., how contacts should be made, who should accompany the client, and what information should be available to the screening team. If possible, DDD should provide professional consultation to the crisis screening units when needed.

C. Interagency effort targeting a specific dually diagnosed population

The task force recognizes the need for specialized programs for those persons with developmental disabilities who have been classified as dually diagnosed. Extensive planning has been completed for a pilot program for developmentally disabled individuals with mental health problems, to be conducted on the grounds of the Ancora Psychiatric Hospital. However, this program has not yet received the funding needed to begin full operation. In keeping with the recommendation that DDD and DMH&H provide leadership in the cooperative development of a broad continuum of services to meet the mental health needs of persons with developmental disabilities, the task force supports the passage of Assembly Bill 2265 and Senate Bill 624, which will provide full funding through DDD and DMH&H for this Ancora program on dually diagnosed persons.

Once the program is funded, the task force recommends a close monitoring of this program for at least one year because it is designed to meet the needs of a very specific population. The task force urges the development of additional joint programs in both institutional and community settings to meet the diverse needs of the dually diagnosed population.

D. Interagency support for mental health screening bill (A. 114ACS/S. 3392SCS)

This bill mandates the provision of short-term acute psychiatric care in community hospitals. The task force recommends, as a condition for its support, the expansion of this bill to ensure access to these services for all persons with developmental disabilities. When this condition has been met, the task force recommends that DDD join DMH&H in support of this bill.

2. Regional Office Level

Case mediation

When interdivisional problems arise regarding service delivery to specific clients, the task force recommends the use of the case mediation process, already established in each county, to ensure optimum client benefits. In addition to settling disagreements, this process will enhance communication between divisions and help to identify the systematic policy and procedure issues that may be contributing to specific problems.

Conclusion: Future of Mental Health Developmental Disabilities Task Force

The task force recognizes the need for an ongoing monitoring of DDD's and DMH&H's adherence to task force recommendations during Stage II of Project Redirection. Therefore, it recommends the selection of one member of the current task force to serve on the Stage II steering committee. This action will permit the task force to carry out one of its primary responsibilities—the internal monitoring of the accomplishment of Stage I initiatives.

ADDENDUM TO TRAINING TASK FORCE REPORT

Several other Project Redirection task forces identified training needs that were not addressed by the Training Task Force. The recommendations that relate specifically to training for the Division of Developmental Disabilities (DDD) staff and provider agencies are the following:

1. Additional training for all components of the intake process should be provided for the southern regional office intake staff. Training will be provided by the UAF. (See Intake/Eligibility Task Force report.)
2. Training should be provided for case management and program support unit staffs. A two-day course providing an overview of developmental disabilities was presented by the UAF, June 16-17, 1986. (See Intake/Eligibility Task Force report.)
3. Training of all relevant personnel should be completed prior to the statewide initiation of the proposed intake system. The Intake/Eligibility Task Force conducted a training needs assessment of all intake unit personnel in August 1985. (A summary of the results of this survey can be found in Appendix XV, Intake/Eligibility.) Therefore, it is recommended that the results of this survey form a basis for the topics to be addressed in the training provided for intake unit personnel. The task force also recommends the development of a plan to train all relevant divisional staff in the new intake procedures and to provide them with an overview of developmental disabilities. This should be done in conjunction with the UAF. (See Intake/Eligibility Task Force report.)
4. DDD should contact and use existing experts and resources, e.g., ABLEDATA and National Rehabilitation Information (1-800-346-2742), for technical methods and adaptive devices that afford more independence and mobility for developmentally disabled persons. Information should be disseminated through training provided for DDD staff. (See Related Services Task Force report.)
5. To determine the types of evaluations and re-evaluations needed when a client presents specified functional limitations and developmental disabilities, DDD should designate an appropriate staff to review literature and programs currently serving developmentally disabled persons. Findings should be included in staff training. This should be done by September 1, 1986. (See Related Services Task Force report.)
6. A list of resources and training topics in the field of rehabilitation engineering should be developed. (See Employment Task Force report.)
7. The following items should be incorporated into training programs for appropriate staff:
 - A. Staff training concerning non-mentally-retarded, developmentally disabled individuals
 - B. Assessment of employment opportunities within geographical areas of client residence
 - C. Training in vocational evaluation instruments (evaluation and types of training offered by sheltered workshops)
 - D. Familiarity with work-related behavior of the client to help him/her successfully adapt to a job
- C. Staff training in the DVR system and services
(See Employment Task Force report.)
8. A training module for guardianship should be developed. (See Guardianship/Advocacy/Self-Direction Task Force report.)

9. Guardianship training should be implemented for
- A. Professional staff employed by DDD and by service provider agencies under contract with DDD
 - B. Other agencies and organizations serving the developmentally disabled population
 - C. Family care and skill development home sponsors
 - D. Parent groups and private guardians

(See Guardianship/Advocacy/Self-Direction Task Force report.)

10. Training seminars on advocacy for developmentally disabled persons should be provided (by June 1, 1987) on a regional and county-by-county basis to agencies and individuals. Participants should include representatives from local chapters or units of organizations involved with developmentally disabled people (e.g., United Cerebral Palsy, the Epilepsy Foundation, the New Jersey Council of Organizations and Schools for Autistic Children and Adults, and the Association for Retarded Citizens), school social workers, the Division of Vocational Rehabilitation counselors, and County Offices for the Handicapped. The regional offices of Community Services should plan and organize these seminars, but the actual content should be developed by a team involving DDD's Office of Community Education, the Department of the Public Advocate (Division of Advocacy for the Developmentally Disabled), Citizen's Advocacy, and a provider agency. Areas to be addressed should include
- A. Techniques and strategies for effective advocacy
 - B. Ways to gain access to the service system
 - C. Procedures for applying for services
 - D. Eligibility criteria
 - E. Appeal process

(See Advocacy/Guardianship/Self-Direction Task Force report.)

11. A training module should be developed (by May 31, 1987) with specific content for
- A. Training clients in self-advocacy skills. One important aspect of this training should focus on client participation in the development or review of the IHP or other program plan.
 - B. Orienting and training staff, group home and skill development home providers, etc., regarding the principles of self-advocacy as well as techniques and strategies that effectively direct clients toward increasing independence and self-advocacy skills.
 - C. Orienting and training parents and siblings in principles of self-advocacy and fostering self-advocacy skills in their developmentally disabled family members.

This training recommendation should be seen as addressing three aspects (clients, parents, and staff) that are intrinsically correlative and mutually complementary. (See Advocacy/Guardianship/Self-Advocacy Task Force report.)

12. Have in place ongoing self-direction and self-advocacy training for all clients, staff, parents, and siblings. (See Advocacy/Guardianship/Self-Direction Task Force report.)
13. Additional joint training programs should gradually be provided to staffs at all DDD and DMH&H facilities. After the emergency and crisis intervention curriculum has been administered and evaluated, the possibility of adapting it for use in DDD community-based settings should be explored. With added information from knowledgeable DMH&H personnel, a training model can be developed to emphasize the mental health needs of developmentally disabled clients in community settings and teach workers how to appropriately identify mental health crises. (Information on this curriculum can be found

under the specific recommendations in the Mental Health/Developmental Disabilities Task Force report.)

Thorough training of DDD case managers is clearly needed to increase their knowledge of clients' mental health needs and to improve their ability to effectively gain access to community resources. Additional case managers are also critically needed. The task force supports the recommendation of its predecessor, the Task Force on Crisis Prevention and Intervention for Persons with Developmental Disabilities in Group Homes, in regard to the need for more case managers and suggests that resources should be allocated toward developing additional training programs only if the programs are developed in conjunction with the creation of additional case management positions. This dual commitment is necessary if training programs are to be effective. (See Mental Health/Developmental Disabilities Task Force report.)

14. A training need exists for physicians completing their psychiatric training at the University of Medicine and Dentistry of New Jersey—Robert Wood Johnson Medical School. In response to this need, the task force recommends that the UAF, by means of its pre-service training program, develop and coordinate a training module. (See Mental Health/Developmental Disabilities report.)

Several task forces—Employment, Housing, Transportation, and Mental Health/Developmental Disabilities—recommended the creation of new staff positions that include responsibility for resource development and coordination of relevant training components. If these staff positions are created, corresponding training recommendations should be incorporated into DDD's training plans.

The Related Services Task Force made training recommendations in regard to personal care attendants and respite care providers:

1. DDD should establish minimum standards for adequate training of personal care attendants and respite care providers.
2. DDD should provide training for these service providers if it is deemed necessary.

These recommendations should receive further consideration as the services are developed and specific training needs are identified.

PROJECT REDIRECTION: STAGE II

Mission Statement and Project Functions

During Stage II, Project Redirection will continue to advise, consult with, and give technical assistance to New Jersey's Division of Developmental Disabilities (DDD) as the division's service system is redesigned to provide appropriate services to eligible persons with developmental disabilities—regardless of the presence of a diagnosis of mental retardation. Project Redirection will meet its obligations by performing the following functions:

1. Coordinating the Planning Process

Project Redirection, under the direction of its coordinator, will provide a structural framework in which DDD can proceed with its redesigning efforts. The coordinator will take an active role in the planning process by chairing the primary steering committee, providing technical assistance to the various interagency and content work groups, and actively participating in the work of the advisory committee.

2. Monitoring of the Planning and Implementation Process

The Project Redirection assistant coordinator, under the direction of the coordinator, will monitor the current efforts of the various work groups through continual contact with work group chairpersons. Chairpersons will receive technical assistance from the Project Redirection staff on an as-needed basis. The assistant coordinator, as an active participant in the intake/eligibility work group, will take a leadership role in the monitoring of the newly operating intake process.

As DDD implements Stage I and Stage II recommendations, its accomplishments and the challenges it encounters will be monitored by the steering committee. Progress reports will be issued to the advisory committee on an as-needed basis.

3. Documenting the Planning Process

The coordinator will be responsible for documenting the planning process and reporting information pertinent to the redesign through monthly reports that will be disseminated throughout the state to all Project Redirection participants, divisional staff, and other known interested persons.

A Stage II report will be published at the end of FY1987, and this information will be disseminated to the appropriate agencies and individuals.

Content Areas

Stage II will examine the following areas, which have an impact on the DDD redesign efforts:

1. Interagency Agreements

The changing role and responsibilities of DDD must be clearly delineated and communicated to other state agencies that provide services to persons with developmental disabilities. This is essential for preventing duplication of services and most importantly for ensuring the creation and delivery of services by the most appropriate agency.

The creation of four interagency work groups is proposed to clarify agency responsibility for the provision of service to individuals with developmental disabilities. The proposed work groups are

A. DDD/Division of Vocational Rehabilitation

- B. DDD/Special Child Health Services
- C. DDD/Division of Youth and Family Services
- D. DDD/Division of Special Education

Each work group will be chaired by a DDD staff person and will be composed of staff members from both agencies as well as consumers of services. Chairpersons will be appointed by the DDD director and will be members of the primary steering committee.

2. Continuation of the Intake/Eligibility Task Force

Due to the complexity of its task and its action-oriented position, the Stage I Intake/Eligibility Task Force should continue and should serve as the formal body monitoring the implementation of the new intake process. It should also recommend policy to the DDD director for adoption by the division.

The chairperson should be a knowledgeable DDD staff person who has been involved in the existing group's work. The chairperson will automatically become a member of the primary steering committee. The DDD director will ask current members to remain on the committee and will make replacements as needed from DDD and the private sector.

3. New Work Groups

To provide adequate assistance for DDD as it redesigns its service system, two work groups should be formed during Stage II:

A. Intake/eligibility for children

A separate work group is needed to put into operation the eligibility criteria for children. This group, although separate from the continuing Intake/Eligibility Task Force, must be intimately familiar with the foundational work of that task force. Coordination between these two groups is essential for attaining a uniform intake system. The work group should be composed of knowledgeable child development specialists and DDD staff familiar with the structure and procedures of the intake unit. Its chairperson, who will also be on the primary steering committee, should be a DDD employee.

B. Client assessment for services

To appropriately and thoroughly assess individual program needs for persons determined eligible for services, a formal standardized interdisciplinary team assessment process must be established. Many efforts have been and are being made to do this. This work group will integrate those efforts and take into consideration the new intake system and, most importantly, the diversified needs of the new client population.

The group will be composed of representatives from the regional staff and from the central office's Program Support Unit, the UAF Project Case Management coordinator, and other appropriate staff. The group chairperson, a DDD staff person, will also serve on the primary steering committee.

3. Stage II Structure

A. Steering committee

This executive review group, chaired by the Project Redirection chairperson, will include all work group chairpersons as well as other DDD staff members appointed to the committee by the director. The steering committee will be charged with reviewing the recommendations of the ongoing work groups and the project advisory committee. The steering committee will also be responsible for internally monitoring the division's efforts to accomplish during Stage II the redesign initiatives from Stage I.

The steering committee will meet on the third Wednesday of every month.

Meeting schedule: October 15, November 19, and December 17, 1986; January 21, February 18, March 18, April 15, May 20, and June 17, 1987

B. Advisory committee

The advisory committee will be composed of service consumers, parents and/or guardians of service consumers, private provider agency representatives, and one ex-officio member from each of the following: the Division of Advocacy for the Developmentally Disabled, the University Affiliated Facility, and the Developmental Disabilities Council. The chairperson of the advisory group will be appointed by the DDD director and will be either a consumer, parent, or guardian. Current advisory committee members who fit the new membership category can choose to remain on the committee.

The committee will be charged with reviewing DDD's ongoing efforts to redesign its service system to meet the diverse needs of eligible persons with developmental disabilities. The committee will advise the DDD director on what actions it thinks the division should take to provide quality services for DDD's new client population.

The advisory committee will meet three times a year on the fourth Tuesday of the month.

Meeting schedule: October 28, 1986; March 24 and June 23, 1987

APPENDIX I INTRODUCTION

PROJECT REDIRECTION ADVISORY COMMITTEE MEMBERS

Chairperson: Kathleen Miller, University Affiliated Facility (UAF) at Robert Wood Johnson Medical School

Joseph Bender, Occupational Training Center

Jane Berezow, Department of Human Services (DHS)

Elizabeth M. Boggs, Ph.D., parent

Emil Brisson, Division of Developmental Disabilities (DDD)

Margo Caldy, DDD

John Cole, DDD

Marion Doherty, parent

Gwen Ehlers, DDD

Blanche Ellis, DDD

Goldie Ellis, DDD

Patricia Fettweis, DDD

Joseph Flanagan, DDD

Eric Joice, Epilepsy Foundation of New Jersey (EFNJ)

Thomas Major, DDD

Chester Miros, Ph.D., DDD

Nancy Richardson, Council of Organizations and Schools for Autistic Children and Adults (COSAC)

Patricia Risch, Developmental Services Associates

Linda Robinson, Department of the Public Advocate, Division of Advocacy for the Developmentally Disabled (DADD)

Joan Sapienza, Association for Retarded Citizens, Somerset County Unit (ARC/Somerset)

John Scagnelli, Association for Retarded Citizens, New Jersey (ARC/NJ)

Carol Schnitzler, parent

Leon Skowronski, DDD

Norman Smith, Consumer representative

Ralph Sneed, Ph.D., DDD

Robert Stack, United Cerebral Palsy Associations of New Jersey Inc. (UCPANJ)

Victor Thomas, DDD

Daniel Vaughn, DDD

APPENDIX II INTRODUCTION

TASK FORCE MEMBERS

INTAKE/ELIGIBILITY

Chairperson: Kathleen Miller, University Affiliated Facility (UAF)

Marilyn Babashak, Division of Developmental Disabilities (DDD)

Elaine Baumeister, The Matheny School

Kim Friend, DDD

Flis Larkin, DDD

Francine Lieber, Epilepsy Foundation of New Jersey (EFNJ)

Lynn McClanahan, Princeton Child Development Institute (PCDI)

Marian Roesner, DDD

Mary Sullivan, UAF

Kathleen Szul, DDD

Consultants:

Frank Bowe, Ph.D.

Estelle Brieness, Ph.D.

Judith Schaub, M.S.

Paul J. Zumoff, Ph.D.

STAFF TRAINING

Chairperson: Gwen Ehlers, DDD

Angela Cosentino, UAF

Anthony Gricco, Vineland Developmental Center

Kenneth David Holmes, Eden Acres

Alan Howard, DDD

Kathleen Meyers, Bancroft School

Karol Misa, DDD

Karen Requa, DDD

Patricia Risch, Developmental Services Associates

Carol Schnitzler, parent

Barbra Solem, DDD

Marilyn Stolte, DDD

Robert Tepperman, DDD

RELATED SERVICES

Chairperson: Margo C. Caldys, DDD

Bebe Antell, parent

Goldie Ellis, DDD

Mary Jane Fritsky, DDD

Susan Lenox Goldman, Special Child Health Services, Department of Health

Jan Handleman, Douglas Developmental Disabilities Center

Jane Kavara, New Jersey Spina Bifida Association
Patricia Krupka, Developmental Disabilities Council (DDC)
Diane Mutchler, Middlesex County Office of the Handicapped
David Popiel, Community Health Law Project
Laurene Ryan, DDD
James Steen, New Jersey Head Injury Association
Rosemarie Zarlengo, DDD

EMPLOYMENT

Chairperson: Thomas S. Major, DDD

Thomas Baffuto, Project HIRE (Handicapped Individuals Requiring Employment, United Cerebral Palsy Association of New Jersey)
Joseph Bender, Burlington Occupational Training Center
Mary DeRiso, Division of Vocational Rehabilitation Services, Department of Labor
Margo Falco, EFNJ
Daniel Kelly, Cumberland Rehabilitation Center
Jenny Lesse, DDD
Rebecca Milton, Eden Institute
Fred Perrine, DDD
Robert Stack, United Cerebral Palsy Association of New Jersey (UCPNJ)
Karen Storm, Eden Institute
Leslie Wexler, Matheny School
Ina White, (UAF)

ADVOCACY/GUARDIANSHIP/SELF-DIRECTION

Chairperson: Chester Miros, Ph.D., DDD

Gerald Conway, parent
Thomas Conway, DDD
Peggy Dervitz, DDD
Mary Fiorito, ARC/NJ
Darlene LaRue, consumer
Nancy Richardson, Council of Organizations and Schools for Autistic Children and Adults (COSAC)
Linda Robinson, DADD
Lorraine Travaglione, ARC/NJ
Ellen Walters, DDD

HOUSING

Chairperson: Blanche Ellis, DDD

Russell Carlini, DDD
John Cole, DDD
Wendy Crook, Mercer County ARC
Patricia Fetweiss, DDD
Alex Gallione, Spectrum for Living
David Holmes, Eden Acres
Anita Kneeleay, United Cerebral Palsy of Monmouth and Ocean Counties, Inc.
Edward Kopelson, Community Health Law Project
Richard Royce, Spectrum for Living
Norman Smith, Consumer representative

Kurt Stofko, United Cerebral Palsy of Monmouth and Ocean Counties, Inc.
Victor Thomas, DDD
Marianne Vermeer, UCPNJ

TRANSPORTATION

Chairperson: Leon Skowronski, DDD (represented by Loretta Bolger)

Joseph Chapkowski, Middlesex County Transportation Department (for William Waldman)
John Conover, DDD
Sally DeVito, UCPANJ (for Robert Stack)
James Ferruggiaro, DDD
Warren Gopel, EFNJ
David Holmes, Eden Institute
Steve Jannick, New Jersey Transit Special Services Citizens Advisory Committee
Roberta McIntyre, New Jersey Department of Transportation
Gregory Miller, DDD (for James Ferruggiaro)
Rebecca Milton, Eden Institute (for David Holmes)
John Scagnelli, ARC/NJ
Robert Stack, UCPANJ
William Waldman, Middlesex County Department of Human Services

RECODIFICATION

Chairperson: Emil Brisson, DDD

Randall Blume, DDD
Elizabeth M. Boggs, Ph.D., parent
James Evanochko, DDD
Madeleine Helfrey, DDD
Gretchen Jacobs, DDC
Walter Kalman, Sussex ARC
Kathleen O'Blennis, DADD
Carolyn Roscoe, DADD
Robert Smith, DDD
Donald Zdanowicz, DDD

MENTAL HEALTH/DEVELOPMENTAL DISABILITIES

Chairperson: Ellen Levine, UAF

Jane Berezow, Department of Human Services (DHS)
Maureen Borland, Division of Mental Health and Hospitals (DMH&H)
Cathleen Cassidy, DMH&H
Philip Conti, DDD
Barbara DeLorenzo, DHS
Nancy Erickson, New Jersey Association of Deaf-Blind, Inc.
Dawn Feyer, DHS (for Barbara DeLorenzo)
Joan Kakazcik, Ph.D., DDD
Barbara Lynch, DMH&H (for Cathleen Cassidy)
Edith Regan, Special Child Health Services, Department of Health
Reuben Schonebaum, Ph.D., DDD
Ralph Sneed, Ph.D., DDD

APPENDIX I
INTAKE/ELIGIBILITY TASK FORCE
CRITICAL ADAPTIVE BEHAVIORS INVENTORY

INTRODUCTION

The legislation that established the Division of Developmental Disabilities (DDD) states that "developmental disability means a severe, chronic disability of a person which: (1) is attributable to a mental or physical impairment or combination of mental or physical impairments; (2) is manifest before age 22; (3) is likely to continue indefinitely; (4) results in substantial functional limitations in three or more of the following areas of major life activity, that is, self-care, receptive and expressive language, learning, mobility, self-direction, and capacity for independent living or economic self-sufficiency; and (5) reflects the need for a combination and sequence of special interdisciplinary or generic care, treatment or other services which are of life-long or extended duration and are individually planned and coordinated..."

Criterion (4) of the above definition of developmental disability provides the primary rationale for the Critical Adaptive Behaviors Inventory (CABI). Criterion (4) mandates that eligibility for DDD services be in part dependent upon the functional assessment of the real life limitations resulting from the applicant's physical and/or mental impairments. It is inferred that inclusion in a disability and/or disease classification is neither necessary nor sufficient to satisfy criterion (4). A valid assessment of the applicant's current functional abilities is required. This is the role of the CABI in the DDD intake process.

DESCRIPTION

The CABI is specifically designed to facilitate the screening of adult applicants to the DDD by assessing the applicant's functioning in the 6 areas of Major Life Activity specified in the DDD legislation. The intent is to assess only behaviors that are critical for independent adaptation to the ordinary demands of adult life.

A variety of Ability Statements are presented within each Major Life Activity. Each statement describes a critical ability and where appropriate the component skills that comprise the ability. In some instances examples are offered to clarify various aspects of the statement. Some Ability Statements assess primarily physical abilities, some assess primarily mental abilities, and others a combination of physical and mental abilities. There is space for short comments following each statement wherein the intake worker may record the specific strengths and weaknesses of the applicant's performance.

Each Ability Statement is presented in the positive, that is, it describes a critical ability, not a deficiency. The intake worker's task is to assess whether the applicant possesses the ability as stated (scored "YES"), or does not possess that ability (scored "NO"). If the intake worker is not able to reach a "YES" or "NO" conclusion, for whatever reason, provision is made for recording a no conclusion response (scored "?").

CRITICAL ADAPTIVE BEHAVIORS INVENTORY

The CABI provides for the recording of information from four sources for each Ability Statement. The sources are: direct observation by the intake worker (OBSERVATION), available documents such as psychological reports, medical reports, allied health specialty evaluations, and school records (DOCUMENTS), self-report by the applicant (APPLICANT), and verbal reports by members of the applicant's family, personal care assistants, or other reliable individuals (INFORMANT).

In addition to the Ability Statements there is an Applicant Data Sheet that provides for the recording of demographic and other applicant information necessary for the intake process. It also provides for a convenient and traditional (non-threatening) starting point for the administration of the CABI.

ADMINISTRATION

The CABI is intended for administration by a trained intake worker. The Applicant Data Sheet and Ability Statements provide the basis for a structured interview and functional assessment wherein the intake worker systematically gathers information about the applicant. The process will normally proceed as follows:

1. The intake worker provides the applicant (and informant) with an overview of the DDD and the rationale for requiring a functional assessment.
2. The intake worker asks the applicant to reiterate, in the applicant's own words, the rationale for the functional assessment. This is to ensure that the applicant (and informant) understand the process and will therefore cooperate fully, and also to provide an opportunity for the intake worker to observe the applicant's ability to learn new information and concepts. Ability Statement III-6 can be completed at this time.
3. The intake worker interviews the applicant (and informant) using the Applicant Data Sheet to structure the interview, but maintaining enough flexibility to follow-up on opportunities for observation of the applicant's functional skills. For example, Ability Statements II-1, II-2, II-3, and II-7 may be observed and recorded during this part of the interview.
4. The intake worker continues the interview using the Ability Statements for structure. The intake worker has the option of paraphrasing the Statements to suit the situation, reading them directly to the applicant, or asking the applicant to perform relevant activities that may offer the opportunity to observe several abilities simultaneously.
5. After all the Ability Statements have been completed (the DOCUMENTS source of information may be completed later) the intake worker reviews the results with the applicant (and informant).
6. If necessary, documents are collected and the relevant information recorded under the appropriate Ability Statements.

CRITICAL ADAPTIVE BEHAVIORS INVENTORY

7. The CABI is scored and a Determination of Functional Eligibility made.

While the majority of the assessment will normally be accomplished during a visit to the applicant's place of residence, the intake worker is encouraged to be creative in arranging for opportunities to observe the applicant's behavior directly in a variety of situations. For example, the intake worker can insist on speaking to the applicant personally on the phone, if at all possible, when arranging the home visit. Parts of the receptive and expressive language assessment can be completed at that time. It follows that there is no required order to the assessment of the 6 areas of Major Life Activity, or the specific Ability Statements within an area. Likewise, entries can be made for the four sources of information in any order as the information is developed.

Direct observation by the intake worker is the preferred source of information. Every effort should be made to reach a "YES" or "NO" conclusion for each Ability Statement. It should be noted here that direct observation does not necessarily mean that the intake worker must observe the applicant performing or attempting to perform the entire and exact activity described in the Ability Statement. Some judgment must be applied. For example, in assessing the applicant's ability to bathe independently it is not required that the applicant actually undress and bathe in front of the intake worker. A simulated bath may be employed, wherein the applicant is asked to go through the motions of taking a bath, perhaps even transferring into and out of the tub or shower while clothed. Also, if the applicant is unable to perform a component skill in a chain of skills, then a "NO" verdict may be reached without observing the remaining component skills. For example, if it has already been observed that the applicant cannot put on outerclothes independently, then it is not necessary to assess whether or not underclothes can be put on or taken off independently. The answer is negative to "dresses and undresses self independently..." and a "NO" is recorded for this Ability Statement under OBSERVATION.

Since there is provision for the no conclusion response ("?") an entry should be made under all four sources of information for every Ability Statement. This will help to ensure that items are not skipped accidentally and that the maximum amount of information has been developed.

SCORING

Each Major Life Activity is first scored independently. If one (or more) Ability Statement is marked "NO" under OBSERVATION then the applicant has a SUBSTANTIAL FUNCTIONAL LIMITATION in that Major Life Activity. If all the Ability Statements are marked "YES" or "?" under OBSERVATION, and all Statements marked "?" under OBSERVATION are marked "YES" under at least one other Source of Information, then the applicant has NO SUBSTANTIAL FUNCTIONAL LIMITATION in that Major Life Activity. If neither of the above two definitive findings are established, then the applicant has a POSSIBLE FUNCTIONAL LIMITATION in that Major Life Activity.

CRITICAL ADAPTIVE BEHAVIORS INVENTORY

After all 6 of the Major Life Activities are scored as above, the results are transferred to the Summary Sheet. Each of the Major Life Activities is marked as SUBSTANTIAL FUNCTIONAL LIMITATION, NO SUBSTANTIAL FUNCTIONAL LIMITATION, or POSSIBLE FUNCTIONAL LIMITATION. A total (1-6) is arrived at for each of these columns, and then a DETERMINATION OF FUNCTIONAL ELIGIBILITY is made. If the SUBSTANTIAL FUNCTIONAL LIMITATION column totals 3 or more, then the applicant is ELIGIBLE. If the NO SUBSTANTIAL FUNCTIONAL LIMITATION column totals 4 or more, then the applicant is NOT ELIGIBLE. If neither of the above two definitive findings are established, then there is FURTHER ASSESSMENT REQUIRED.

CRITICAL ADAPTIVE BEHAVIORS INVENTORY

ABILITY STATEMENTS

MAJOR LIFE ACTIVITY: CATEGORY I SELF-CARE	SOURCE OF INFORMATION			
	OBSERVATION YES: NO: ?	DOCUMENTS YES: NO: ?	APPLICANT YES: NO: ?	INFORMANT YES: NO: ?
1: Applicant feeds self independently including cutting food, lifting food and drink to mouth, chewing, and swallowing when served a prepared meal and using personally owned assistive devices if necessary. Comments:				
2: Applicant toilets self independently including transferring to toilet, wiping self, and transferring from toilet using personally owned assistive devices if necessary. If alternative methods of urinary voiding or fecal evacuation are applicable, applicant independently completes entire routine. Comments:				
3: Applicant independently selects attire appropriate as to season and activity. Comments:				
4: Applicant dresses and undresses self independently including underclothes, outerclothes, socks, and shoes, using personally owned adapted clothes and/or assistive devices if necessary. Comments:				
5: Applicant bathes self independently including transfer to tub or shower, adjusting water, scrubbing, transfer from tub or shower, and drying, using personally owned assistive devices if necessary. Comments:				
6: Applicant self-administers oral medications including opening container, obtaining correct dosage, placing medications in mouth, swallowing (with or without liquids, as appropriate), and closing container, using personally owned assistive devices if necessary. Comments:				
7: Applicant's abilities in the self-care category of major life activities, as measured by the above statements, are functional most of the time. That is, if functional ability fluctuates across time due to the nature of the developmental disability, the applicant is impaired in self-care less than an average of one full day a month for reasons related to the developmental disability. Comments:				

CATEGORY I

_____ SUBSTANTIAL FUNCTIONAL LIMITATION (One or more Statement marked No under Observation.)

_____ NO SUBSTANTIAL FUNCTIONAL LIMITATION (All Statements are marked Yes or ? under Observation, and all Statements marked ? under Observation are marked Yes under at least one other Source of Information.)

_____ POSSIBLE FUNCTIONAL LIMITATION (Neither Substantial Functional Limitation or No Substantial Functional Limitation.)

APPLICANT'S NAME: _____

ID#: _____

CRITICAL ADAPTIVE BEHAVIORS INVENTORY

ABILITY STATEMENTS

MAJOR LIFE ACTIVITY: CATEGORY II RECEPTIVE AND EXPRESSIVE LANGUAGE	SOURCE OF INFORMATION			
	OBSERVATION	DOCUMENTS	APPLICANT	INFORMANT
	YES: NO: ?	YES: NO: ?	YES: NO: ?	YES: NO: ?
1: Applicant can hear and comprehend the content of ordinary spoken conversations in the applicant's primary language, using a hearing aid and/or other personally owned assistive devices if necessary. Comments:				
2: Applicant has sufficiently intelligible speech to communicate common words to individuals of casual acquaintance in the community. Comments:				
3: Applicant has sufficient vocabulary, grammatic ability, and/or non-verbal communications skills to conduct ordinary business with individuals of casual acquaintance in the community. Comments:				
4: Applicant can conduct a functional two way conversation over the telephone such as scheduling personal appointments or obtaining consumer information, using an amplified telephone and/or other personally owned assistive devices if necessary. Comments:				
5: Applicant has sufficient sight and reading ability to access and comprehend ordinary written text such as in popular magazines and newspapers, using eyeglasses, dictionary, and/or other personally owned assistive devices if necessary. Comments:				
6: Applicant has sufficient physical skills, vocabulary, and grammatic ability to write or type a functional letter such as a personal note to a friend or a response to a business or government communication, using eyeglasses, typewriter, wordprocessor, and/or other personally owned assistive devices if necessary. Comments:				
7: Applicant's abilities in the receptive and expressive language category of major life activities, as measured by the above statements, are functional most of the time. That is, if functional ability fluctuates across time due to the nature of the developmental disability, the applicant is impaired in receptive and expressive language less than an average of one full day a month for reasons related to the developmental disability. Comments:				

CATEGORY II

----- SUBSTANTIAL FUNCTIONAL LIMITATION (One or more Statement marked No under Observation.)

----- NO SUBSTANTIAL FUNCTIONAL LIMITATION (All Statements are marked Yes or ? under Observation, and all Statements marked ? under Observation are marked Yes under at least one other Source of Information.)

----- POSSIBLE FUNCTIONAL LIMITATION (Neither Substantial Functional Limitation or No Substantial Functional Limitation.)

APPLICANT'S NAME: _____

ID#: _____

CRITICAL ADAPTIVE BEHAVIORS INVENTORY

ABILITY STATEMENTS

MAJOR LIFE ACTIVITY: CATEGORY III LEARNING	SOURCE OF INFORMATION			
	OBSERVATION YES: NO: ?	DOCUMENTS YES: NO: ?	APP. ICANT YES: NO: ?	INFORMANT YES: NO: ?
1: Applicant has sufficient hearing and/or sight, and mental ability to access and comprehend the content of ordinary television and/or radio programming using a hearing aid, eyeglasses, and/or other personally owned assistive devices if necessary. Comments:				
2: Applicant has sufficient sight, sense of touch, and/or sense of smell to identify common domestic products and is able to explain their common uses. Comments:				
3: Applicant has sufficient money skills, and sight and/or sense of touch to identify pennies, nickels, dimes, and quarters, and to calculate the value of any combination of these coins up to \$2.00. Comments:				
4: Applicant has sufficient time skills, and sight, hearing, and/or sense of touch to tell the time of day to the quarter hour including A.M. and P.M., given a clock or watch appropriate for the applicant and using eyeglasses, hearing aid, and/or other personally owned assistive devices if necessary. Comments:				
5: Applicant is able to provide a reasonably complete and accurate personal history including, for example, name, date of birth, place of birth, place of residence (including street address, city, and state), telephone number, Social Security number, nature and cause of disabling condition, education and/or employment data, etc. Comments:				
6: Applicant is able to state in general terms the reason for this functional assessment after being given a full explanation by the intake worker. Comments:				
7: Applicant's abilities in the learning category of major life activities, as measured by the above statements, are functional most of the time. That is, if functional ability fluctuates across time due to the nature of the developmental disability, the applicant is impaired in learning less than an average of one full day a month for reasons related to the developmental disability. Comments:				

CATEGORY III

- _____ SUBSTANTIAL FUNCTIONAL LIMITATION (One or more Statement marked No under Observation.)
- _____ NO SUBSTANTIAL FUNCTIONAL LIMITATION (All Statements are marked Yes or ? under Observation, and all Statements marked ? under Observation are marked Yes under at least one other Source of Information.)
- _____ POSSIBLE FUNCTIONAL LIMITATION (Neither Substantial Functional Limitation or No Substantial Functional Limitation.)

APPLICANT'S NAME: _____

ID#: _____

CRITICAL ADAPTIVE BEHAVIORS INVENTORY

ABILITY STATEMENTS

MAJOR LIFE ACTIVITY: CATEGORY IV

MOBILITY

SOURCE OF INFORMATION

OBSERVATION	DOCUMENTS	APPLICANT	INFORMANT
YES NO ?	YES NO ?	YES NO ?	YES NO ?

1: Applicant moves about independently and safely within both indoor and outdoor environments using a wheelchair, crutches, braces, cane, and/or other personally owned assistive devices if necessary.

Comments:

2: Applicant gets up and down low curbs up to six inches high independently and safely using wheelchair, crutches, braces, cane, and/or other personally owned assistive devices if necessary.

Comments:

3: Applicant is able to pick up a towel from the floor using personally owned assistive devices if necessary.

Comments:

4: Applicant gets in and out of bed independently and safely using personally owned assistive devices if necessary.

Comments:

5: Applicant independently and safely operates ordinary household equipment such as TV, radio, oven/range, vacuum cleaner, etc. using personally owned assistive devices if necessary.

Comments:

6: Applicant crosses streets with light traffic and/or streets with traffic lights independently and safely.

Comments:

7: Applicant gets in and out of his/her place of residence independently and safely, including locking and unlocking doors.

Comments:

8: Applicant's abilities in the mobility category of major life activities, as measured by the above statements, are functional most of the time. That is, if functional ability fluctuates across time due to the nature of the developmental disability, the applicant is impaired in mobility less than an average of one full day a month for reasons related to the developmental disability.

Comments:

CATEGORY IV

_____ SUBSTANTIAL FUNCTIONAL LIMITATION (One or more Statement marked No under Observation.)

_____ NO SUBSTANTIAL FUNCTIONAL LIMITATION (All Statements are marked Yes or ? under Observation, and all Statements marked ? under Observation are marked Yes under at least one other Source of Information.)

_____ POSSIBLE FUNCTIONAL LIMITATION (Neither Substantial Functional Limitation or No Substantial Functional Limitation.)

APPLICANT'S NAME: _____

ID#: _____

CRITICAL ADAPTIVE BEHAVIORS INVENTORY

ABILITY STATEMENTS

MAJOR LIFE ACTIVITY: CATEGORY V SELF-DIRECTION	SOURCE OF INFORMATION			
	OBSERVATION	DOCUMENTS	APPLICANT	INFORMANT
	YES: NO: ?	YES: NO: ?	YES: NO: ?	YES: NO: ?
1: Applicant makes essentially independent daily personal decisions regarding a schedule of activities including when to get up, what to do (e.g. work, leisure, home chores, etc.), and when to go to bed. Comments:				
2: Applicant makes essentially independent major life decisions such as choice of type and location of living arrangements, marriage, and career choice. Comments:				
3: Applicant possesses adequate social skills to establish interpersonal relationships with friends and/or relatives. Comments:				
4. Applicant makes essentially independent daily personal decisions regarding diet including when to eat, where to eat, and what to eat. Comments:				
5. Applicant is essentially independent in managing personal finances including making decisions regarding allocation of financial resources and keeping track of financial obligations. Comments:				
6: Applicant is capable of self-referral for routine medical and dental checkups and treatment including selecting the doctor, arranging for an appointment, and providing a medical history as necessary. Comments:				
7: Applicant demonstrates sufficient assertiveness skills to express personal opinions, request assistance when needed, and protect self from exploitation by others. Comments:				
8. Applicant's abilities in the self-direction category of major life activities, as measured by the above statements, are functional most of the time. That is, if functional ability fluctuates across time due to the nature of the developmental disability, the applicant is impaired less than an average of one full day a month for reasons related to the developmental disability. Comments:				

CATEGORY V

_____ SUBSTANTIAL FUNCTIONAL LIMITATION (One or more Statement marked No under Observation.)

_____ NO SUBSTANTIAL FUNCTIONAL LIMITATION (All Statements are marked Yes or ? under Observation, and all Statements marked ? under Observation are marked Yes under at least one other Source of Information.)

_____ POSSIBLE FUNCTIONAL LIMITATION (Neither Substantial Functional Limitation or No Substantial Functional Limitation.)

APPLICANT'S NAME: _____

ID#: _____

CRITICAL ADAPTIVE BEHAVIORS INVENTORY

ABILITY STATEMENTS

MAJOR LIFE ACTIVITY: CATEGORY VI CAPACITY FOR INDEPENDENT LIVING OR ECONOMIC SELF-SUFFICIENCY	SOURCE OF INFORMATION			
	OBSERVATION	DOCUMENTS	APPLICANT	INFORMANT
	YES: NO: ?	YES: NO: ?	YES: NO: ?	YES: NO: ?
1. Applicant independently prepares light meals on occasion. Comments:				
2. Applicant is aware of a variety of community activities such as religious services, continuing education, sports, volunteer organizations, movies, shopping, visiting friends, etc. and independently selects and participates in at least one on a regular basis. Comments:				
3. Applicant can be left alone for periods of time up to 24 hours without being considered to be at risk. Comments:				
4. Applicant is able to state in general terms several requirements of being a good worker, such as being prompt, attending regularly, accepting supervision, getting along with coworkers, etc. Comments:				
5. Applicant is able to state several approaches to finding a job, such as going to an employment agency, responding to ads, using personal contacts, etc. Comments:				
6. Applicant is able to state a vocational preference and describe with reasonable accuracy the education and skills required. Comments:				
7. Applicant demonstrates insight regarding the obstacles to independent living and/or employment consequent to the applicant's disability. Comments:				
8. Applicant's abilities in the capacity for independent living or economic self-sufficiency category of major life activities, as measured by the above statements, are functional most of the time. That is, if functional ability fluctuates across time due to the nature of the developmental disability, the applicant is impaired in capacity for independent living or economic self-sufficiency less than an average of one full day a month for reasons related to the developmental disability. Comments:				

CATEGORY VI

----- SUBSTANTIAL FUNCTIONAL LIMITATION (One or more Statement marked No under Observation.)

----- NO SUBSTANTIAL FUNCTIONAL LIMITATION (All Statements are marked Yes or ? under Observation, and all Statements marked ? under Observation are marked Yes under at least one other Source of Information.)

----- POSSIBLE FUNCTIONAL LIMITATION (Neither Substantial Functional Limitation or No Substantial Functional Limitation.)

APPLICANT'S NAME: _____

ID#: _____

CRITICAL ADAPTIVE BEHAVIORS INVENTORY

SUMMARY SHEET

MAJOR LIFE ACTIVITY	SUBSTANTIAL FUNCTIONAL LIMITATION	NO SUBSTANTIAL FUNCTIONAL LIMITATION	POSSIBLE FUNCTIONAL LIMITATION
CATAGORY I: SELF-CARE			
CATAGORY II: RECEPTIVE AND EXPRESSIVE LANGUAGE			
CATAGORY III: LEARNING			
CATAGORY IV: MOBILITY			
CATAGORY V: SELF-DIRECTION			
CATAGORY VI: CAPACITY FOR INDEPENDENT LIVING OR ECONOMIC SELF-SUFFICIENCY			
		TOTALS	

SUMMARY COMMENTS:

[illegible]

Intake Worker's Name

Intake Worker's Signature _____

Date Assessment Completed _____

DETERMINATION OF FUNCTIONAL ELIGIBILITY

ELIGIBLE (Substantial Functional Limitation in 3 or more Major Life Activity categories.)

_____ NOT ELIGIBLE (No Substantial Functional Limitation in 4 or more Major Life Activity categories.)

_____ FURTHER ASSESSMENT REQUIRED (Neither Eligible or Not Eligible.)

APPLICANT'S NAME: _____ ID#: _____

APPENDIX II
INTAKE/ELIGIBILITY TASK FORCE
DIVISION OF DEVELOPMENTAL DISABILITIES

REQUEST FOR SERVICE

Client's name	Date	Serial No.	
Also known as	Office	Telephone	Letter

Demographics

Social Security No.
Date of birth
Marital status
Sex

Present living arrangement

Type	Telephone
Name	County
Address	
P.O. Box	
City, state, zip	

Present program/employment

Type	Telephone
Name	County
Address	
P.O. Box	
City, state, zip	

Admission

Region of admission
Referral source
Services requested

Developmental disabilities

☐ Mental retardation
☐ Cerebral palsy
☐ Spina bifida
☐ Head injury
☐ Autism
☐ Epilepsy
☐ Other (specify)
Age at onset of primary disability (specify disability)

Name of informant

Relationship to client
Telephone

Contact person

Address
Telephone

Status code

Opened _____
Closed _____

Assigned to
Referred to

(Back Side of REQUEST for SERVICES)

DIVISION OF DEVELOPMENTAL DISABILITIES

Client's name _____ Serial No. _____

Interviewer's name _____

Comments

APPENDIX II (continued)
INTAKE/ELIGIBILITY TASK FORCE
GUIDE FOR COMPLETION OF REQUEST FOR SERVICE FORM

The following information may be included under certain categories:

Present living arrangement

Own home, shelter, foster family, etc.

Present program/employment

Public school, workshop, competitive employment

Admission

Referral source: DYFS, DMH&H, self, ARC, etc.

Services requested: Alternate living arrangement, home assistance,
day programming, case management, etc.

Name of informant

The individual contacting the Division of Developmental Disabilities for services
on behalf of the applicant or in many instances, the applicant

Relationship to client

Family, agency worker, child study team, etc.

Contact person

The individual you may need to contact to obtain further information and/or
to relate information to on behalf of the client. The contact person will not
necessarily be the informant.

APPENDIX III
INTAKE/ELIGIBILITY TASK FORCE

CONFIRMATION LETTER B

ACKNOWLEDGEMENT OF REQUEST FOR SERVICE

Dear

Thank you for contacting the Division of Developmental Disabilities. As discussed in our telephone conversation on _____, it is recommended that you contact (referral agency) _____ at _____, where you may obtain assistance at this time.

Enclosed is additional information concerning the Division of Developmental Disabilities for your use if you decide to apply for services at a later date.*

If you have any questions, please feel free to call _____ between _____

Very truly yours,

*Include: DDD brochure
Community Services brochure
Factsheet for intake, appeal, and guardianship processes

APPENDIX IV
INTAKE/ELIGIBILITY TASK FORCE

CONFIRMATION LETTER A

ACKNOWLEDGEMENT OF REQUEST FOR SERVICE

Dear

Thank you for contacting the Division of Developmental Disabilities
on _____. Your request for services has
been assigned to (intake worker's name) _____
who will be calling to make an appointment with you.

Enclosed is additional information regarding the Division of
Developmental Disabilities.* If you have any questions or comments,
please call _____ between _____.

Sincerely yours,

*Include: DDD brochure
Community Services brochure
Factsheets for intake, appeal and guardianship processes

APPENDIX V INTAKE/ELIGIBILITY TASK FORCE

The following list of documents should be used, where appropriate, for securing additional information:

Physician's statement* (See Appendix XII, Intake/Eligibility.)

School reports

Child study team evaluation

Diagnosis

Hospital reports

Psychological evaluation**

Psychiatric evaluation

Medical evaluation

Physical therapy evaluation

Occupational therapy evaluation

Rehabilitation reports

DVR report

Speech evaluation

Other

*To be used when other supporting medical documentation is not sufficient.

**If the applicant is identified as mentally retarded, a psychological evaluation with an I.Q. score must be obtained to verify that the applicant was mentally retarded before he/she was age eighteen. (This verification is needed for community care waiver purposes.)

APPENDIX VI
INTAKE/ELIGIBILITY TASK FORCE



State of New Jersey

Department of Human Services

Division of Developmental Disabilities

APPLICATION FOR DETERMINATION OF ELIGIBILITY FOR FUNCTIONAL SERVICES
(See reverse side for instructions.)

Name of client _____
Last First Middle

Sex _____ Date of birth _____ Place of birth _____
Month Day Year

In accordance with revised statutes, state of New Jersey,
Section 30:4-25.2, application is made to the commissioner of the Department
of Human Services for a determination of eligibility for the functional
services of said department for the client named above. This application
is made under R.S. 30:4-25.2 by virtue of the relationship indicated
below:

For clients under 18

____ Natural parents
____ Legal guardian
____ Agency or other

For clients over 18

____ Self
____ Guardian of the person
____ Court of competent
jurisdiction

Signature _____ Date _____
Signature _____ Date _____

Do not write below this line

ELIGIBILITY DETERMINATION

The client named above has been determined

____ Eligible for functional
services of the Division
of Developmental Disabilities*

____ Eligible for ICF/MR
functional services*

____ Not eligible for functional
services of the Division
of Developmental Disabilities

____ Not eligible for
ICF/MR functional
services

Date _____
Signature _____
Title _____
Signature _____
Title _____

Date _____

*If eligible, application for Agreement for Functional Services
should be made on the attached form.

(Back Side of APPLICATION for DETERMINATION)

APPLICATION TO DETERMINE ELIGIBILITY

Application for determination of eligibility for functional services for a person who is under age eighteen and is believed to be developmentally disabled may be made to the commissioner by

1. His/her parent or guardian
2. A child-caring agency, hospital, clinic, or other appropriate agency (public or private) or by a physician having care of the minor (provided that written consent of the parent or guardian or the Division of Youth & Family Services, under its care and custody program, has been obtained)
3. A juvenile court having jurisdiction over the minor

Application for determination of eligibility for functional services for any person over age eighteen may be made by

1. A developmentally disabled individual over eighteen on his/her own behalf
2. The guardian of an adjudicated mentally incompetent adult
3. Any court of competent jurisdiction where mental deficiency was an issue and where determination of eligibility was found to be in the interest of the allegedly mentally deficient person

After eligibility is determined, another application is required to admit the client to the functional services for which he/she was found eligible.

AGREEMENT FOR FUNCTIONAL SERVICES

The applicant's agreement to receive functional services of the department may be made under the following four classes:

- Class F: Application to the commissioner by the parent, guardian, or person or agency having care and custody of a minor or by the guardian of a minor or by the guardian of a mentally deficient adult
- Class G: Application to the commissioner by a developmentally disabled person over eighteen on his/her own behalf
- Class H: Application to the commissioner by a juvenile court having jurisdiction over an eligible developmentally disabled minor
- Class I: Application to the commissioner with an order of commitment to the custody of the commissioner issued by a court of competent jurisdiction during or following criminal process involving the eligible developmentally disabled person

APPENDIX VII
INTAKE/ELIGIBILITY TASK FORCE
DIVISION OF DEVELOPMENTAL DISABILITIES

CLIENT INFORMATION

Client's name _____ Serial No. _____

Guardian information

Guardianship type	Date of appointment
County of appointment	
Court/guardianship review date	
Relationship to client	
Name	Telephone
Address	
City, state, zip	

Other Agency Involvement

Entitlements

_____ DYFS
_____ CBVI
_____ DMH&H
_____ Other (specify)
Name
Address
City, state, zip
Telephone

SSI _____ Amount _____
SSA _____ Amount _____
Medicare/Medicaid # _____
Other _____

Medications

Psychotropic or behavior modification medications Y/N _____
Medication for chronic persistent medical conditions Y/N _____

Medical conditions

Previous hospitalization Y/N _____

_____ Diabetic	_____ AIDS
_____ Hepatitis B	_____ Pica
_____ Seizures	_____ Allergies
_____ Other (specify)	

Date _____
Address _____
Purpose _____

Family data

Father's name	Date of birth	Address
Mother's name	Date of birth	Address
Siblings		
Other significant members		

Records/evidence of developmental disability and where available

- 1.
- 2.
- 3.
- 4.
- 5.

(Back Side of CLIENT INFORMATION)

DIVISION OF DEVELOPMENTAL DISABILITIES

Client's name _____ Serial No. _____

Interviewer's name _____

Comments

APPENDIX VII (continued)

CHARACTERISTICS

1. SELF-CARE

Substantial functional limitation____ No substantial functional limitation____
Possible functional limitation____

Feeding:	Independent____	Needs assistance____	Undetermined____
Dressing:	Independent____	Needs assistance____	Undetermined____
Toileting:	Independent____	Needs assistance____	Undetermined____
Bathing:	Independent____	Needs assistance____	Undetermined____

Comments (Include list of specific assistive devices.)

2. RECEPTIVE/EXPRESSIVE LANGUAGE

Substantial functional limitation____ No substantial functional limitation____
Possible functional limitation____

Means of communication: Verbal____ Sign language____ Assistive devices____
Does not communicate____

Speech:	Intelligible____	Impaired____	Undetermined____
Hearing:	Functionally adequate____	Impaired____	Undetermined____
Vision:	Functionally adequate____	Impaired____	Undetermined____

Comments (Include list of specific assistive devices.)

3. LEARNING

Substantial functional limitation____ No substantial functional limitation____
Possible functional limitation____

Can add the value of coins____ Cannot add the value of coins____ Undetermined____
Can tell time____ Cannot tell time____ Undetermined____

4. MOBILITY

Substantial functional limitation____ No substantial functional limitation____
Possible functional limitation____

Ambulation: Ambulatory without assistance____ Independent with assistive
devices____ Dependent____

Comments (Include list of specific orthopedic)

(Back Side of CHARACTERISTICS)

5. SELF-DIRECTION

Substantial functional limitation_____ No substantial functional limitation_____
Possible functional limitation_____

Ability to set daily schedule of activities: Independent_____ Dependent_____
Undetermined_____

Ability to manage personal finances: Independent_____ Dependent_____
Undetermined_____

Can establish interpersonal relationships_____ Cannot establish interpersonal
relationships_____ Undetermined_____

6. INDEPENDENT LIVING/ECONOMIC SELF-SUFFICIENCY

Substantial functional limitation_____ No substantial functional limitation_____
Possible functional limitation_____

Can be left alone for 24 hours_____ Cannot be left alone for 24 hours_____
Undetermined_____

Independent in preparing light meals_____ Dependent in all meal preparation_____
Undetermined_____

7. BEHAVIOR

Danger to self_____ others_____ property_____

Runs away_____

No behavior problems_____

APPENDIX VII (continued)
GUIDE FOR COMPLETION OF CLIENT INFORMATION FORM

Guardianship information

Guardianship type, including private guardians such as parents and relatives

Court/guardianship review date, if applicable

Records/evidence of developmental disability available

Evidence documented by any professional evaluation
(psychological, medical, etc.)

Interviewer's name

The name of the individual who takes the call, but not necessarily the intake worker who will be assigned to the case

Comments

A section where the worker can further elaborate, clarify, etc., such areas as family situation, current client situation, medications, and services requested

APPENDIX VIII
INTAKE/ELIGIBILITY TASK FORCE

DIVISION OF DEVELOPMENTAL DISABILITIES ELIGIBILITY CHECK LIST

CLIENT'S NAME _____

A client's eligibility for DDD services is dependent on documentation that verifies that he/she has met the established criteria listed below.

Please indicate "yes" or "no" to the following questions and specify the source of this information.

The term "developmental disability" means a severe, chronic disability of a person that

1. Is attributable to a mental or physical impairment or combination of mental or physical impairments Yes ___ NO ___ Source _____
2. Is manifested before the age of 22 Yes ___ No ___ Source _____
3. Is likely to continue indefinitely Yes ___ No ___ Source _____
4. Results in substantial limitations in 3 of the following major life activities Yes ___ No ___ Source _____
 - a. Self-care Yes ___ No ___ Source _____
 - b. Receptive and expressive language Yes ___ No ___ Source _____
 - c. Learning Yes ___ No ___ Source _____
 - d. Mobility Yes ___ No ___ Source _____
 - e. Self-direction Yes ___ No ___ Source _____
 - f. Capacity for independent living and/or economic self-sufficiency Yes ___ No ___ Source _____
5. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care treatments or other services that are life-long or of extended duration and are individually planned and coordinated Yes ___ No ___ Source _____

The checklist must answer "yes" to statements 1 - 5 if the client is to be considered developmentally disabled.

For CCW purposes

Client is mentally retarded _____ Verification of I.Q. score obtained _____
Client is not mentally retarded _____

Person completing form _____

APPENDIX IX
INTAKE/ELIGIBILITY TASK FORCE

CLIENT'S SOCIAL HISTORY

Client's name _____
Date of birth _____
Social Security No. _____
Intake worker's name _____
Date _____

Presenting request

Worker should specify services requested by client/family and factors that precipitated the request for services.

Current situation

This section should include a brief overview of a client's strengths, limitations, needs, family situations, plans, and goals.

The intake worker should make recommendations for the initiation of a determination of the need for guardianship services if either of the following conditions exist:

- A. The applicant's disability is determined to be mental retardation.
- B. The applicant shows substantial functional limitation in the areas of learning and/or self-direction on CABI.

Conclusions and recommendations

Support with documentation and/or assessment tool evaluation, the rationale for a worker's recommendation for a client's eligibility for functional services.

APPENDIX X
INTAKE/ELIGIBILITY TASK FORCE



State of New Jersey
Department of Human Services
Division of Developmental Disabilities

Agreement For Functional Services

In accordance with the eligibility determination dated _____
for _____ indicating that he/she is
eligible for functional services of the Division of Developmental Disabilities,
I (we) request that the client be admitted for services at the earliest opportunity.

Date	Signature of applicant(s)	Relationship
_____	_____	_____
_____	_____	_____

Name(s) and address(es) (include zip code) of parent(s) or guardian:

This application should be completed, signed, and returned to the regional
office by _____. If it is not returned by that date,
it will be assumed that services are not desired at this time.

APPENDIX XI
INTAKE/ELIGIBILITY TASK FORCE



State of New Jersey
Department of Human Services

Division of Developmental Disabilities

Client's name _____

Community Care Waiver

The Waiver Program has been explained, and the following location has been chosen for services:

_____ Community Services

_____ Institutional Services

It is understood that this choice can be reversed.

Signature _____ Date _____

Signature _____ Date _____

DDD-CCW #1
6/86

APPENDIX XII
INTAKE/ELIGIBILITY TASK FORCE
STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES
PHYSICIAN'S STATEMENT

Name of patient _____ Male _____ Female _____

Address _____

Telephone _____ Date of birth _____

1. Has patient ever been diagnosed as disabled? Yes _____ No _____

2. Age at onset of disability _____

3. List all chronic disabilities _____

4. Takes medication? Yes _____ No _____ LIST ALL MEDICATIONS BELOW

MEDICATION	DOSAGE	FREQUENCY	SIDE EFFECTS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5. Is patient allergic to any medication? Yes _____ No _____

If yes, specify. _____

6. Does patient have other allergies? Yes _____ No _____

If yes, explain. _____

7. Does patient require assistive devices? Yes _____ No _____

If yes, specify. _____

Name of physician (please print) _____ Date _____

Address _____ Telephone () _____

Physician's signature _____

APPENDIX XIII
INTAKE/ELIGIBILITY TASK FORCE
CRITICAL ADAPTIVE BEHAVIORS INVENTORY

PILOT STUDY FEEDBACK

1. Interviewer's Name: _____ Agency: _____

2. How many CABI's had you administered prior to this one? _____

3. How long did it take to administer this CABI? _____

4. Describe the location where this CABI was administered: _____

5. Describe the "applicant's" receptivity to the CABI: _____

6. Describe any general problems or questions encountered during administration of this CABI: _____

7. Describe any problems or questions encountered with regard to the APPLICANT DATA SHEET: _____

8. Describe any problems or questions encountered with regard to specific ABILITY STATEMENTS:

ABILITY STATEMENT _____:

ABILITY STATEMENT _____:

ABILITY STATEMENT _____:

ABILITY STATEMENT _____:

ABILITY STATEMENT _____:

9. Describe any problems or questions encountered with regard to scoring this CABI: _____

10. Is the DETERMINATION OF FUNCTIONAL ELIGIBILITY consistent with your professional judgment? Yes _____ No _____

If NO, explain why you believe this "applicant" should be classified differently: _____

APPENDIX XIV
INTAKE/ELIGIBILITY TASK FORCE

DEVELOPMENT OF THE CRITICAL ADAPTIVE BEHAVIORS INVENTORY

SUMMARY REPORT

Background

Consequent to the establishment of the Division of Developmental Disabilities (DDD), the Project Redirection Advisory Board (Board) was created to guide and assist the transition from an agency serving the mentally retarded only to one serving the mentally retarded and the non-mentally retarded developmentally disabled. The Board then formed nine Task Forces to address various aspects of this transition. One Task Force was designated Intake/Eligibility and its role was "to recommend operationalized criteria for determining eligibility for functional services" (Project Redirection Interim Report One).

The criteria to be operationalized was the definition of a developmental disability as set by Senate Bill 1826 that established the DDD. It states that "developmental disability means a severe, chronic disability of a person which: (1) is attributable to a mental or physical impairment or combination of mental or physical impairments; (2) is manifest before age 22; (3) is likely to continue indefinitely; (4) results in substantial functional limitations in three or more of the following areas of major life activity, that is, self-care, receptive and expressive language, learning, mobility, self-direction, and capacity for independent living or economic self-sufficiency; and (5) reflects the need for a combination and sequence of special interdisciplinary or generic care, treatment or other services which are of life-long or extended duration and are individually planned and coordinated..."

The Intake/Eligibility Task Force early on identified criteria (4) as the most critical and most difficult aspect of this definition. The intake process would need to provide for the functional assessment of applicants in the six areas of major life activity specified, and there was no existing mechanism to accomplish that task, especially considering the wide range of developmental disabilities that were to be screened, and the desire to keep the intake process manageable and efficient. It was decided that a functional assessment instrument that could be administered by Intake Unit personnel was needed. However, after an extensive review of existing instruments, it was concluded that none satisfied the needs of the DDD. At this point the author, who had been following the progress of the Intake/Eligibility Task Force through contacts with one of its members, submitted a proposal for the development of a new functional assessment instrument designed specifically to facilitate the screening of adult applicants to the DDD in a manner consistent with the mandate of the legislation and the capabilities of the Intake Unit. The proposal was reviewed and approved by the Intake/Eligibility Task Force, the Project Redirection Advisory Committee, and the DDD Executive Staff, and development of what was to become the Critical Adaptive Behaviors Inventory (CABI) started in October, 1986.

Concept

As outlined in the proposal, the goal was to develop an instrument that was organized along the lines of the six categories of major life activities specified in the legislation so that eligibility decisions could flow directly from the results of the functional assessment. The expectation was that the CABI would be administered by Intake Unit personnel during the initial visit to the applicant's place of residence directly following the signing of the official application to DDD. Given the probable time limitations determined by the intake worker's schedule and the applicant's patience or endurance, a target time limit of two hours was set for administration of the CABI. Additional constraints were that the CABI require no specialized equipment or setting for administration, and that no specific professional credentials be necessary to administer the CABI.

The Intake/Eligibility Task Force members and the author recognized that it was unrealistic to expect that one short instrument administered by generic intake workers could result in definitive eligibility decisions for every applicant. From the start, it was assumed that some applicants would require more in-depth assessment by a variety of specialists. The CABI was to be designed to screen in or out as many adult applicants as possible while identifying those that needed further assessment. In this way the majority of applicants could move through the intake process quickly and those that required closer scrutiny could receive greater attention, expediting their applications, also. The Regional Service Assessment Team was identified as the most probable system for conducting these in-depth assessments, but other options such as contracting with interdisciplinary teams from specialized private facilities and referrals to private specialist practitioners were also considered possibilities. Regardless of the choice, the CABI and the intake workers would have professional support, as needed.

Additionally, it was decided that the CABI was to address primarily criterion (4) of the legislative definition of developmental disability, that is, the functional limitations of the applicant. Therefore, the CABI would need to be packaged with other intake forms that addressed the remaining eligibility criteria. Various members of the Intake/Eligibility Task Force assumed responsibility for coordinating those activities.

One other important conceptual issue should be mentioned here. It is that all concerned with the development of the intake process identified the need for extensive staff training regarding not just the intake forms and instruments, but also the nature of physical disabilities in general.

The actual format and content of the proposed instrument was that it would survey the most critical abilities necessary for leading an independent adult lifestyle, that it would prompt the applicant to perform observable behaviors so that the intake worker could verify directly whether the applicant was functionally limited in each of the major life activities, and that in addition to the observations of the intake worker, it would provide for the recording of information supplied by the applicant, an informant, and available documents.

First Draft

The first draft of the CABI was presented to the Intake/Eligibility Task Force at a meeting on November 6, 1985. It featured a variety of Ability Statements each classified as either a mental ability or a physical ability. The intent was to allow not only for a determination of functional eligibility but also a differential determination of whether the applicant was primarily physically disabled, primarily mentally disabled, or both. After review and discussion it was decided that too much was being attempted at the intake point and that the CABI needed to focus simply on the general determination of functional eligibility.

Second Draft

A major revision of the CABI was performed to eliminate the physical-mental dichotomy of items. Additionally, critiques provided by members of the Intake/Eligibility Task Force were reviewed and recommendations for specific item modifications incorporated into the revision.

The second draft was delivered to the Intake/Eligibility Task Force in mid-December and also sent to three independent experts in the field of developmental disabilities. They were contracted to provide detailed feedback related to the content validity of the CABI. The three individuals were: Frank Bowe, Ph.D.-Research Psychologist; Judith Schaub, RPT-Physical Therapist; Estelle Breines, M.A., OTR-Occupational Therapist.

Third Draft

Once again the CABI was revised based upon the combined recommendations of the above listed experts. At this point the CABI was considered ready for a trial with disabled subjects, but not actual applicant's to DDD. An Interim Pilot study was designed by the Intake/Eligibility Task Force and the author, utilizing the intake workers of the Southern Regional Office of DDD and selected personnel and clients from eight facility/agencies serving a range of developmentally disabled individuals. The facility/agencies were: Atlantic County Opportunity Center; Bancroft Community; Burlington County Occupational Training Center; Epilepsy Foundation of New Jersey; Matheny School/Hospital; Mercer County Office for the Handicapped; Monmouth County United Cerebral Palsy; and Princeton Child Development Institute. The design of the Interim Pilot study was as follows:

1: A full day training session was held on February 28, 1986 to train the participating staff in the administration of the CABI. Training techniques included showing a video tape of the author administering the CABI to a severely disabled young man in his own apartment; lecture; discussion; and hands on experience administering the CABI to volunteer disabled subjects, with feedback from the author and members of the Intake/Eligibility Task Force.

2: Three to five subjects were selected from volunteer clients at each of the facility/agencies. Subjects were chosen to represent a range of developmental disabilities at a variety of functional levels.

3: Each subject was assessed twice with the CABI, once by a Southern Regional Office intake worker who was not familiar with the subject, and once by a staff member of the facility/agency who was familiar with the subject.

4: Every administration of the CABI included an Interim Pilot feedback sheet that was completed by the person administering the CABI, providing detailed information regarding the conduct of the session and problems that were encountered.

5: The author reviewed all the CABI's and compiled some basic statistics and formed overall impressions of the results.

6: A formal debriefing and feedback session was held on April 11, 1986. The author solicited further feedback from the participants via group discussion and paired reviews of selected completed CABI's to clarify discrepancies in results between the two administrations of the CABI to the same subject.

Interim Pilot - Results

While the Interim Pilot study was not a tightly controlled scientific experiment, it did yield useful quantitative and qualitative results. They are summarized as follows:

1: A total of 60 CABI's were administered. There were 34 different subjects - 26 subjects received two administrations of the CABI as planned, and 8 subjects received only one administration for a variety of logistical reasons.

2: Thirteen staff members administered the CABI's, averaging 4.6 CABI's each.

3: The average time used to administer the CABI was 94 minutes, well within the target limitation of 120 minutes.

4: Of the 60 CABI's, 43 (72%) resulted in determinations of Eligible; 9 (15%) resulted in determinations of Not Eligible; and 7 (12%) resulted in determinations of Further Assessment Required. One CABI was not scored.

5: There were 2 (3%) cases where the administrator of the CABI thought the subject should have been found Eligible but the CABI found the subject Not Eligible.

6: There was 1 (2%) case where the administrator of the CABI thought the subject should not have been found Not Eligible but the CABI found the subject Eligible.

7: There was 1 (2%) case where one Administration of the CABI found the subject Eligible while the second administration (different administrator) found the subject Not Eligible.

Overall, the author was very pleased with the results. The distribution of Eligible, Not Eligible, and Further Assessment Required determinations seems to be plausible. The few cases that presented discrepancies are bothersome, but considering that the CABI is still under development and the administrators inexperienced in its use, improvement can be expected, and hopefully all such questionable results eliminated.

Draft Four

The voluminous data gathered in the Interim Pilot has been reviewed in detail, and the many appropriate recommendations for improvements incorporated into draft four. Most of these changes are small modifications to clarify the authors intent in specific items. There has also been a minor change in the wording of the scoring criteria to simplify that task. A few frequently criticized items have been replaced. In general, changes have been in the direction of creating items that prompt more easily observable behaviors.

The biggest change can be found in the last item of each major life activity. The most significant problem that kept surfacing throughout the development of the CABI was the issue of fairly assessing those individuals whose developmental disability may be in remission or under control at the time of the assessment, but who none-the-less were substantially limited by episodic illness or impairment. These last items were added in this draft to assure that these individuals are identified and given equal opportunity for eligibility. It is likely that many of these applicants will fall into the Further Assessment Required category, but this is preferable to an erroneous Not Eligible.

The next step is the design of a true field trial of the CABI and the entire intake process with actual applicants to DDD. The author will continue to work with the Intake/Eligibility Task Force on this project and the expectation is that the field trial will be implemented in July, 1986.

Respectfully submitted May 9, 1986

Paul J. Zumoff, Ph.D.

APPENDIX XV

INTAKE/ELIGIBILITY TASK FORCE

SUMMARY OF TRAINING NEEDS ASSESSMENT SURVEY

A subcommittee of the Intake/Eligibility Task Force developed a training needs assessment survey, which was completed by four intake supervisors and fourteen intake workers in August 1985. This survey determined the types and amount of in-service training that intake unit personnel received over the past year and evaluated the staff's perceived training needs pertaining specifically to the new developmentally disabled client population. The results of the survey were incorporated into the task force's recommendations for intake staff training.

Demographic Information

Of the four supervisors who completed the survey, only two had previously worked with developmentally disabled clients. Two of the supervisors had bachelor's degrees, one in psychology and the other in sociology. The other supervisors had master's degrees, one in guidance and the others in social work.

Ten of the fourteen intake workers who completed the survey had previous work experience with mentally retarded or developmentally disabled individuals. Eight workers had bachelor's or master's degrees in social work, three had bachelor's degrees in psychology, and three had master's degrees in either rehabilitation, guidance, or counseling.

Training Topics Identified

Methodology

If less than twenty-five per cent of the respondents received training in a particular area within the last twelve months, this lack of training is noted in this report as a significant training gap. Topics identified by more than twenty-five per cent of the respondents as high or moderate training priorities are also cited.

General Topics

1. Significant training gaps: history of mental retardation and developmental disabilities movement, funding, and developmental model
2. Training priorities: developmental model, nature of federal and state laws and policy, normalization principle, funding, division general orientation, and least restrictive alternative principle

Developmental Disabilities

1. Significant training gap: severe sensory impairments
2. Training priorities: spina bifida, neurological impairments, physical disabilities, severe sensory impairments, autism, cerebral palsy, seizure disorders, mental retardation

Health

1. Significant training gaps: identifying/developing community resources for referral of medical/dental services, interfacing with state agencies
2. Training priorities: medications and side effects, community resources, interfacing with state agencies

Sensory/Motor Skills

1. Significant training gaps: hearing impaired and deaf individuals, motor skills—role of occupational and physical therapies, visually impaired and blind individuals, special needs of an individual with multiple sensory impairments
2. Training priorities: same as training gaps

Communication Skills

1. Significant training gaps: basic information on measuring expressive/receptive language skills, review of alternative/augmentative communication, sign language
2. Training priorities: same as training gaps

Activities of Daily Living

1. Significant training gaps: review of mobility disorders, assessment of capacity for independent living, assessment of self-care skills
2. Training priorities: same as training gaps

Vocational/Educational Skills

1. Significant training gaps: continuum of vocational opportunities, interfacing with state agencies—Division of Vocational Rehabilitation, interfacing with state agencies—Department of Education, assessment of an individual's capacity for economic self-sufficiency
2. Training priorities: same as training gaps

Social Interactions

1. Significant training gaps: identification and intervention with family at risk, understanding parental concerns—community placement, understanding effects of specific disabilities on family members
2. Training priorities: same as training gaps

Self-Concept/Behavior

1. Significant training gaps: assessment of an individual's capacity for self-direction, increasing positive self-concept, management of the aggressive client, client self-abuse
2. Training priorities: same as training gaps

Leisure/Recreation

1. Significant training gap: identification and referral to generic services
2. Training priority: same as training gap

Intake Worker: Role and Responsibilities

1. Significant training gaps: how to be an effective interdisciplinary team member, networking for services, interpreting standardized test results, interpreting behavioral data, conflict resolution, writing and recordkeeping skills, relating with the public, crisis management, telephone skills, interviewing skills
2. Training priorities: same as training gaps plus the following: relating effectively with the public, interpreting standardized test results, interpreting behavioral data/reports

Summary

Nearly every potential training topic mentioned in this survey was cited by intake workers and supervisors as a significant training need. The two major topic areas most cited were (1) substantive areas pertaining to specific developmental disabilities and (2) sensory/motor skills.

ORGANIZATION STRUCTURE FOR IMPLEMENTATION OF COMMUNITY TRAINING PROGRAMS

RESOURCES

OHRD

CIVIL
SERVICE

UAF

SPECIAL
CONTRACTS

Department
Training
Office

University
Affiliated
Facility

Colleges
Consultants
Organizations

CENTRAL OFFICE STRUCTURE

Director Community
Training Programs

- Resource
- Development
- Quality Assurance

Director Division
Training Programs

- Resource
- Development
- Quality Assurance

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REGIONAL STRUCTURE

NRO
Training Unit
Supervisor

- Coordinate
- Schedule
- Implement

CRO
Training Unit
Supervisors

- Coordinate
- Schedule
- Implement

SRO
Training Unit
Supervisor

- Coordinate
- Schedule
- Implement

- Developmental Centers
- Central Office DD
- Dept. & Division
Initiatives

POSITIONS

Group Home Trainer (1)
Home Provider Trainer (1)
Staff Dev. Trainer (1)*
Sr. Clerk Transcriber (1)*

G.H.T. (1)(1)*
H.P.T. (2)
S.D.T. (2)*
S.C.T. (2)*

G.H.T. (1)
H.P.T. (1)
S.D.T. (1)*
S.C.T. (1)*

Existing Staff Positions

3 Group Home Trainers
4 Home Provider Trainers
(Skill, Family Care, Respite)

*Needed Staff Positions

4 Regional Training Unit Supervisors
4 Staff Development Trainers
4 Senior Clerk Transcribers
1 Group Home Trainer

APPENDIX I
TRAINING TASK FORCE

APPENDIX II

TRAINING TASK FORCE

PRELIMINARY COST ESTIMATES

	Quantity	Description	Unit Price	Total
Staff				
	4	Training unit supervisors, range 25 (principal community program specialists)	\$25,700	\$102,800
	5	Trainers, range 22	22,200	111,000
	4	Clerks (senior clerk transcribers)	11,758	47,032
Equipment and Office Supplies				
	13	Desks	175	2,275
	13	Chairs	100	1,300
	4	Typewriters	900	3,600
	4	File cabinets	170	680
	4	Sets of office supplies	100	400
	4	Sets of VCR equipment with monitor playback machines	2,200	8,800
	24	Cassette tapes	8	192
	2	Film projectors	1,000	2,000
	2	Slide projectors	450	900
	4	Sets of training supplies	200	800

APPENDIX I

RELATED SERVICES TASK FORCE

RELATED SERVICES DIRECTORY

Treatment Services

Dental treatment
Outpatient medical care
Physical therapy
Speech therapy
Occupational therapy
Coordinated home health care
Medical supplies and equipment provision (adaptive devices and aids and their maintenance, rehabilitation engineering)

Instruction and Skill Development Services

Life skills education (activities of daily living)
Family growth control and planning
Techniques for handicapped persons
Mobility and travel training
Special family and parent instruction and training

Social Growth and Development Services

Social recreation (projects to foster mainstreaming rather than specialized program development)
Adult day care
Telephone reassurance
Informal socialization

Supportive Assistance and Treatment Services Counseling

Legal advice and consultation
Housing maintenance services
Chore service (including grocery shopping)
Respite care
Personal care (should include flexible services provided by trained personnel, training for existing service providers if needed, a service delivery system located near clientele, fees based on a sliding scale structure)
Supportive counseling for personal adjustment
Therapeutic group counseling
Emergency services

Other

Case management services

Volunteer recruitment, training, and placement (use of volunteers by tapping into existing organizations)

Medical insurance (Most coverages have a \$20,000 maximum because a head injury, for example, is usually covered under the psychiatric provisions of medical coverage.)

Cognitive rehabilitation (especially for rehabilitation needs due to head injuries and strokes)

Education interaction

Adult education

Information, referral, and outreach

Networking (with the goal of establishing social support groups)

Community trusts

Self-advocacy

Prevention

Genetic counseling

APPENDIX II
RELATED SERVICES TASK FORCE
NEW JERSEY COMMISSION ON RECREATION
FOR THE HANDICAPPED

SERVICES COUNCIL

County Chairpersons of Project Network

ATLANTIC

Agnes Bell
Atlantic County Office for Disabled
1333 Atlantic Avenue
Atlantic City, N. J. 08401
(609) 345-6700 X2819

BERGEN

Robert Gorman
Bergen County Park Commission
327 Ridgewood Avenue
Paramus, N. J. 07652
(201) 646-3484

BURLINGTON

Hal Williams
Burlington County Unit ARC
1011 Deacon Road
Hainesport, N. J. 08036
(609) 267-5453

CAMDEN

Mary Pat Mignogna
Camden County Park Commission
POB 4210
Cherry Hill, N. J. 08002
(609) 428-9336

CAPE MAY

Marge Murray
Cape May County ARC
POB 275
Rio Grande, N. J. 08242
(609) 465-9349

CUMBERLAND

William Gaskill
Cumberland ARC Evanoff Center
1680 West Sherman Avenue
Vineland, N. J. 08630
(609) 691-9138

ESSEX

Terry McCutcheon, Rec. Ther.
Kessler Institute
240 Central Avenue
East Orange, N. J. 07018
(201) 731-3600 X535

GLOUCESTER

Adele DeLucas
Washington Twp Parks & Rec
POB 1106
Turnersville, N. J. 08012
(609) 589-3227

HUDSON

Nick Starita
UCP Hudson County
1005 Washington Street
Hoboken, N. J. 07030
(201) 656-3779

HUNTERDON

Delores Zukoski
Hunterdon Developmental Center
POB 5220
Clinton, N. J. 08809
(201) 735-4031 X170

MERCER

Frieda Applegate
NRCPL
27 Church Street RD 2
Yardville, N. J. 08620
(609) 298-0566 (609) 890-3839

MIDDLESEX

Dorothy Caruso
Old Bridge Parks & Recreation
1 Old Bridge Plaza
Old Bridge, N. J. 08857
(201) 679-2000

MONMOUTH

Joanne Goldberg
Monmouth County Park System
Newman Springs Road
Lincroft, N. J. 07738
(201) 842-4000 X58

MORRIS

Gail Paradise
Morris County Adaptive Rec Program
POB 123
Morris Plains, N. J. 07950
(201) 455-1288

OCEAN

John Kelly
Ocean County Parks & Recreation
659 Ocean Avenue
Lakewood, N. J. 08701
(201) 269-1844

PASSAIC

Sally Tannenbaum, Acting
Passaic Co. Office on the Disabled
Passaic County Admin. Building
317 Pennsylvania Avenue
Paterson, N. J. 07503
(201) 881-4363

SOMERSET

Patricia Galler
Somerset Co. Park Commissioner
POB 5327
North Branch, N. J. 08876
(201) 526-5650

SUSSEX

James Angle
Newton Memorial Hospital
175 High Street
Newton, N. J. 07860
(201) 383-2121 X295

UNION

Elaine Stemmler
Union Co. Dept. Parks & Rec.
Admin Bldg - Elizabeth Plaza
Elizabeth, N. J. 07207
(201) 527-4912

WARREN

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APPENDIX I HOUSING TASK FORCE

HOUSING OPTIONS

Independent Living

1. Own home, developmentally disabled person is head of of household
2. Senior citizen, HUD units for disabled persons
3. Shared living
4. Transitional programs
5. With assistance (personal care attendant, rent subsidy)
6. Supportive living programs
7. Live-in, work placements

Dependent Living

Disabled person living with his/her family

Sponsored Care Provided

1. Skill development
2. Family care
3. Respite care

Boarding Homes

1. DCA Class C
2. Sheltered boarding homes

Group Homes and Supervised Apartments

Health-Related Facilities

1. Community ICF/DD
2. Nursing homes
3. Residential health care facilities

Institutions

1. State developmental centers
2. Private residential facilities

Out-of-Home Respite Care Provided

1. Person in crisis
2. Person not in crisis

APPENDIX I

TRANSPORTATION TASK FORCE

EXECUTIVE STAFF REVIEW

When the task force presented its final report on April 15, 1986, members of the DDD executive staff indicated that the recommendations outlined by the task force warranted much larger staff additions than those proposed in the report, as well as a reorganization to place the additional and the existing transportation staffs under a new unit within the division. The executive staff members said that this long-range staffing plan was designed to meet personnel needs that will arise as DDD's transportation services expand during the next few years. The plan included the following positions:

Central Office

- Unit director
- Assistant directors (2)
- Training coordinator
- Safety and design technician
- Night scheduler
- Traffic manager
- Clerical workers (2)

Regional Offices (one of each of the following for the northern, lower central, central, and southern regional offices)

- Supervisor
- Computer technician
- Traffic specialist

This staffing plan was announced to the Transportation Task Force at its final meeting on May 8, 1986.

APPENDIX II

TRANSPORTATION TASK FORCE

TRANSPORTATION SYSTEM

As of December 1985, DDD's transportation system included 407 vehicles ranging from small school-bus-type buses with a seating capacity for 8 persons and 2 wheelchairs to vehicles with a seating capacity for 5 persons and 4 wheelchairs. Of these buses 216 are less than 3 years old and are on lease from Classen Corporation. The rest of the buses are owned by the state and serviced by its motor pool.

Currently, the oldest vehicles are being eliminated and replaced with new, slightly larger vehicles with more wheelchair capacity.

In addition to the buses, DDD has 77 vans. However, 51 of these vans are used primarily by crew labor programs to convey the workers (adult activities clients) and equipment to and from work sites.

At the present time, these vehicles cover 445,000 miles per month for a total of 5,340,000 miles per year and a passenger mileage rate of 2,269,500,000 miles per year. The vehicles are dispersed among 18 New Jersey counties but make pickups and deliveries in all 21 counties.

Breakdown of DDD Vehicles

Year/Make	No./Type	Passengers	Wheelchairs
Vehicles without lifts			
1978 CMP	14 buses	16	
1979 CMP	6 vans	8	
1980 CMP	10 vans	12	
1983 Hertz	35 vans	8	
1986 CMP	26 vans	16	
Buses with lifts			
1979 CMP	100 buses	12	2
1983 Classen	186 buses	8	2
1984 Classen	30 buses	8	2

Approximately one third of the fleet can be made available during down time, excluding the crew labor vehicles, which cannot be considered available.

Weekday hours of down time: 10 a.m. to 2 p.m. (in most areas).

APPENDIX I

MENTAL HEALTH/DEVELOPMENTAL DISABILITIES TASK FORCE

SURVEY OF DEVELOPMENTAL DISABILITIES PROVIDER AGENCIES

A survey instrument, similar to the one utilized by the Division of Mental Health and Hospitals, was developed to assess the need for mental health services as perceived by provider agencies serving persons with developmental disabilities. Using a multiple-choice format, the questionnaire asked the respondents to identify their clients in terms of principal diagnoses and presenting problems. It also asked them to indicate the types of services, including typical mental health services, that they provide to their clients. Finally, the survey asked for information about unmet service needs and possible barriers to the delivery of mental health services to developmentally disabled clients.

Over 160 provider agencies serving persons with developmental disabilities were surveyed. The ninety-three agencies that responded reported that seventeen per cent of their clients had been referred to other agencies for mental health services. Of those referred, twenty per cent were turned down or declared ineligible for services.

The most frequently cited diagnosis for developmentally disabled clients was mental retardation. Neurological, physical, or motor impairments were identified somewhat less often. Nearly one third of the agencies indicated that they had clients whose principal diagnosis was a psychiatric condition.

Clients with deficits in daily living skills, difficulty in relating to others, and bizarre behavior or disordered thought as their presenting problems were reported by more than half of the agencies. At least one third of the agencies reported a wide range of presenting problems similar to those in other mental health patients:

1. Depression
2. Anxiety
3. Medical or somatic complaints
4. Lack of financial resources
5. Lack of social support system
6. Organic mental disorders
7. Assaultive or self-abusive behaviors

Substance abuse, legal or criminal problems, physical abuse or neglect, need for temporary shelter, and suicide were among the least frequently cited presenting problems.

The reporting agencies provide their clientele with the typical array of services for developmentally disabled persons, such as training in daily living skills, day programs, and residential programs. They also provide behavior management (two thirds of the reporting agencies), psychotherapy or counseling (one third), medication monitoring (nearly one half), and intervention or other emergency services (more than one fourth) for their clients.

The provider agencies surveyed deliver their services primarily to developmentally disabled clients. Less than twenty per cent reported that they provide services for individuals who are not developmentally disabled. A majority (sixty per cent) of the agencies provide services for members of clients' families. Two of the most often cited needs of families were counseling/emotional support and assistance in learning to cope with disabilities.

Behavior management training and intervention or other emergency services were also frequently identified as family needs. Specific assistance in everyday care, assistance in understanding medication regimes and their effects, and temporary shelter were cited as important family services by more than half of the responding agencies.

When the agencies were asked to identify services needed to better serve the developmentally disabled population, more than half of the agencies cited the need for more services to families. Psychotherapy or counseling, temporary or crisis shelter, and intervention or other emergency services were also frequently cited by the agencies, as was behavior modification. About a quarter of the agencies identified a need for inpatient services and medication monitoring in addition to services already being provided.

The need for additional resources (including staff, space, and administration) was identified most often as a barrier to the delivery of mental health services to developmentally disabled individuals. More than half of the provider agencies cited lack of specialized knowledge about mental retardation by mental health providers as a significant barrier to service. Similarly they cited a lack of knowledge about the implications of the medical or organic characteristics of developmental disabilities for medication treatment.

The lack of interagency involvement and cooperation was seen as a barrier to mental health services by nearly half of the responding agencies. The agencies also indicated a need for special facilities or equipment, ongoing technical assistance, and the expansion of services to individuals with multiple disabilities and severe impairments.

In summary, the responses to the provider survey indicated that the developmentally disabled population presented a range of mental health needs that Division of Developmental Disabilities providers are trying to address to some extent. However, the results also showed that a variety of services, many of them in the category of typical outpatient mental health services, need to be expanded and/or made available to individuals with developmental disabilities.

According to the providers, this could be accomplished with additional mental health resources (staff, space, administrative funds), specialized training for mental health staff, and ongoing technical assistance from developmental disabilities specialists. A key element, if mental health services are to be provided for the developmentally disabled population, is the involvement and cooperation of the various human service agencies.

The survey results also suggested that services should be developed to address the needs of individuals with multiple disabilities and severe impairments. Transportation, as well as special facilities or equipment, may be necessary to ensure accessibility to services for some disabled persons. Finally, task force members found it significant that issues related to family support emerged as a high priority. There was some discussion as to whether these services should be provided by agencies currently serving developmentally disabled persons or whether new delivery modes should be developed. The task force concluded that an in-depth investigation should be done of the specific types of family support services needed.

APPENDIX II MENTAL HEALTH/DEVELOPMENTAL DISABILITIES TASK FORCE

DD-SURVEY HIGHLIGHTS

The survey questionnaires were sent out in October 1985. Return of forms was requested by November 11. The following summary of results is based on all the forms returned by early December, 1985. The response rate was relatively low. About 36 percent of the agencies returned at least one completed form. In terms of program elements, the overall rate was somewhat lower (33%). The best return rate was from Partial Care programs (42%). Inaccuracies in program element codes (use of "all", "A", "D", and "H") and in reporting numbers of DD-eligible clients (e.g. 50 - 100), in addition to the low response rate require that these results should be viewed as gross estimates only. The number of DD-eligible clients reported directly (1604, question 2) represents about six percent of the reported caseload. However, when aggregated from responses to question 4, the number of DD-eligible clients (2872) represents 11.2 percent of the caseload.

Principal Diagnoses, Presenting Problems and Treatment Objectives:

As expected, most respondents (72.5%) reported a psychiatric diagnosis as principal diagnosis for their DD-eligible clients. Almost 56% reported mental retardation as principal diagnosis. The most frequently cited (71.5%) presenting problem was "bizarre behavior-thought disorder". "Problems with daily living" was the second most frequently cited presenting problem (68.6%), and marital or family problems came in third (50.9%).

An equal number of respondents (72.5%) reported their primary treatment objectives were "treatment of client's emotional problems", and "behavior management". Half the respondents reported skill development/training to be their primary treatment objective.

Services provided for and needed by clients and their families:

Psychotherapy (72%), medication monitoring (68.6%) and behavior management (64.7%) were most frequently reported as services provided to DD-eligible clients. Legal and financial services were reported by only five and nine percent respectively. Drug abuse (11.8%), Temporary shelter (11.8%), and Residential services (15.7%) were also reported by a relatively small percentage of the respondents.

However, in responding to the question about additional needed services, residential was the most frequently mentioned service (50%). It was followed by Employment (44.1%), temporary shelters (44.1%), and behavior management training (43.1%). The last figure is interesting in view of the reported amount of such training already provided by 64.7% of the respondents.

Of the responding programs, 39% reported providing services to the families of their DD-eligible clients. Most respondents saw all the services mentioned as important. The lowest frequency of response was given to "specific assistance with everyday care" (53.9%). The highest to "counseling and emotional support" (94.1%).

Issues, problems and prerequisites:

Staff's lack of specialized knowledge was cited most often (69.6%) as a problem for the responding agencies. Most of them were worried about lack of knowledge in the area of physical disabilities (48%) and mental retardation (47.1%). Facilities and equipment were cited as a problem by 50 percent of the responding agencies and lack of pharmaceutical expertise by 34.3 percent.

Staff training needs were analyzed for the entire sample and by program element. In general, all five categories of staff were mentioned by sizeable proportion of the respondents, with mental health workers leading (65.7%) and social workers following closely behind (62.7%). The patterns were somewhat divergent in the separate program elements. Social workers were mentioned most frequently by emergency/screening and outpatient programs while mental health workers were most frequently mentioned by partial Care and residential programs.

When asked about additional prerequisites for better service provision on their part, respondents have chosen most frequently the "involvement and cooperation by other services" option (68.2%). The next frequent choice was for increased staff, and about equal amounts of respondents (40.2% and 42.2%) also required consultation and ongoing technical assistance.

RESULTS OF DDSURVEY

RESPONDING AGENCIES BY COUNTY

COUNTY	AGENCIES	RESPONDING	PERCENT
Atlantic	6	5	69.4
Bergen	12	2	16.7
Burlington	4	3	75.0
Camden	6	2	33.3
Cape May	1	1	100.0
Cumberland	1	1	100.0
Essex	17	9	52.9
Gloucester	1	1	100.0
Hunterdon	3	0	0
Mercer	15	4	26.7
Middlesex	10	2	20.0
Monmouth	10	2	20.0
Morris	8	1	12.5
Ocean	3	1	33.3
Passaic	9	3	33.3
Salem	1	1	100.0
Somerset	2	1	50.0
Sussex	1	0	0
Warren	2	1	50.0
TOTAL	112	40	35.7

RATE OF RESPONDING BY PROGRAM ELEMENT

PE	IN SAMPLE	FUNDED	%
C&E	1	37	2.7
ES	15	53	28.3
IP	3	--	---
QP	26	73	35.6
RES	11	46	23.9
PC	31	73	42.5
OTHER	15*	25	---
TOTAL	102	307	33.2

*Includes SA, CM and coding errors. The 25 in FUNDED are SA + CM.

ESTIMATES OF MENTAL HEALTH DD-ELIGIBLE CLIENTS
WHO ARE SERVED AND WHO ARE REFERRED ELSEWHERE

PE	CASELOAD	DD-ELIGIBLES	%	NOT SERVED	%
C&E	77	5	6.5	1	1.3
ES	2940	106	3.6	57	1.9
IP	43	2	4.6	0	0
OP	15811	915	5.8	95	0.6
PC	1871	287	15.3	43	2.3
RES	256	56	21.9	62	24.2
OTHER	4602	233	5.1	29	0.6
TOTAL	25600	1604	6.3	287	1.1

4. How many of your DD-Eligible clients are male/female?

PE	MALE	%	FEMALE	%
C&E	1	20.0	4	80.0
E/S	1049	74.5	359	25.5
IP	1	50.0	1	50.0
OP	513	59.2	354	40.8
PC	170	60.5	111	39.5
RES	29	51.8	27	48.2
OTHER	143	56.5	110	43.5
TOTAL	1906	66.4	966	33.6

5. Which of the following are used as principal diagnosis
for your DD-Eligible clients? (Check as many as are applicable)

DIAGNOSIS	N	%
Mental Retardation	57	55.9
Neurological Impairment	47	46.1
Psychiatric diagnosis	74	72.5
Substance Abuse	20	19.6
Other	5	4.8

6. Which of the following are often cited as presenting problems of your DD-Eligible clients? (Check as many as are applicable)

PRESENTING PROBLEM	N	%
Affective disorder	44	43.1
Alcohol	28	27.4
Anxiety	40	39.2
Bizarre behavior-Thought dis.	73	71.5
Drugs	23	22.1
Legal/Justice System	16	15.7
Marital/Family	52	50.9
Medical/ Somatic	31	30.4
No economic resources	22	21.6
No social support system	47	46.1
Organic Mental disorder	47	46.1
Physical abuse/ neglect	15	14.7
Problems - daily living	70	68.6
School problems	35	34.3
Suicide attempt/ threat	40	39.2
Self-abuse	20	19.6
Physically assaultive	41	40.2
Destructive to property	41	40.2
Other	9	8.8

7. What are the primary treatment objectives for the DD-Eligible clients enrolled in your program? (Check as many as are applicable)

TREATMENT OBJECTIVES	N	%
Skill Development/training	50	49.0
Treatment of emotional problems	74	72.5
Management of behavior	74	72.5
Client has nowhere else to go	21	20.6
Other	20	20.6

8. What services are you providing to DD-Eligible clients?
(Check as many as are applicable)

SERVICES PROVIDED	N	%
Alcohol services	16	15.7
Daily living skills	54	52.9
Drug abuse services	12	11.8
Education	17	16.7
Employment	18	17.6
Evaluation only	24	23.5
Financial	9	8.8
Legal	5	4.9
Medical/Health related	28	27.5
Medication monitoring	68	66.6
Psychotherapy/counseling	75	72.0
Recreation	43	42.2
Residential	16	15.7
Temporary/crisis shelter	12	11.8
Transportation	35	34.3
Behavior management	66	64.7
Emergency/crisis services	56	54.9

9. Are you currently providing services to family members of DD-Eligible persons?

	N	%
Yes	59	57.8
No	38	37.3

10. In your opinion, what services are important for family members of DD-Eligible clients? (Check as many as are applicable)

SERVICES TO FAMILIES	N	%
Learning to understand and cope with the DD problem	39	87.3
Counseling/emotional support	96	94.1
Specific assistance in everyday care of the DD-person	55	53.9
Behavior management training	79	77.5
Understanding medication regimes/effects	77	75.5
Availability of emergency/crisis services/shelters	72	70.6
Other	9	8.8

11. In addition to what is currently provided, which services are needed to better serve DD-Eligible clients? (Check as many as are applicable)

SERVICES NEEDED	N	%
Alcohol services	16	15.7
Daily living skills	39	38.2
Drug abuse services	15	14.7
Education	34	33.3
Employment	45	44.1
Evaluation only	12	11.8
Financial	30	29.4
Legal	18	17.6
Medical/Health related	25	24.5
Medication monitoring	14	13.7
Psychotherapy/counseling	18	17.6
Recreation	36	35.3
Residential	51	50.0
Temporary shelter	45	44.1
Transportation	37	36.3
Services to families of DD-eligible clients	43	42.1
Behavior management training	44	43.1
Emergency/crisis services	24	23.5

12. Are there special issues and problems you foresee in providing (additional) services to DD-Eligible clients? (Check as many as are applicable)

SPECIAL PROBLEMS	N	%
Staff lack of specialized knowledge	71	69.6
Specific area of lack:		
Mental retardation	48	47.1
Behavior management	38	37.3
Physical disabilities	40	39.2
Neurology	49	48.0
Knowledge/understanding of unique pharmaceutical characteristics of, and needs for medication by these clients	35	34.3
Facilities/equipment	51	50.0
Other	27	26.5

13. Which categories of staff need training?

STAFF	N	%
Psychiatrists	34	33.3
Psychologists	43	42.2
Social workers	64	62.7
Nurses	34	33.3
Mental health workers	67	65.7

CATEGORIES OF STAFF IN NEED OF TRAINING
BY PROGRAM ELEMENT

STAFF	PROGRAM ELEMENT						
	C&E (n=1)	E/S (n=15)	IP (n=3)	OP (n=26)	PC (n=31)	RES (n=11)	OTHER (n=15)
Psychiatrists	--	5	1	11	8	4	5
Psychologists	1	8	1	16	8	4	5
Social Workers	1	10	1	18	17	6	11
Nurses	--	8	2	8	7	3	6
MH workers	1	8	1	14	24	9	9

14. Are there additional prerequisites, other than training,
for your ability to provide better/additional services to
DD-Eligible clients?
(Check as many as are applicable)

PREREQUISITS	N	%
Increased staff	62	60.8
Consultation	41	40.2
Ongoing technical assistance	43	42.2
Involvement and cooperation by other services (e.g., DMR, DYFS, SS)	71	68.2
Other	9	8.8

APPENDIX III

MENTAL HEALTH/DEVELOPMENTAL DISABILITIES TASK FORCE

EMERGENCY AND CRISIS INTERVENTION CURRICULUM TOPICS

Assessment and Intervention

1. Case examples giving specific developmental disability characteristics
2. Handouts that present a general overview of specific developmental disabilities, such as autism, mental retardation, spina bifida, and dyslexia
3. Modification of assessment and intervention to be used with the developmentally disabled client and specific questions that will alert crisis clinicians to possible developmental disabilities
4. Medication assessment—the use of poly-pharmacy for the developmentally disabled client
5. Diagnostic impression—how, in many cases, a mental health diagnosis impeded the developmentally disabled client from returning into the developmental disabilities system; use of DDD consultants by primary crisis screening units to enhance their services

Using Community Resources

1. The need to encourage linkage between DDD, other community services, and the crisis screening unit; major importance of telephone contact between DDD and crisis screener for offering a more comprehensive service
2. Sensitizing the crisis screener to the DDD worker's concerns and difficulties when dealing with the developmentally disabled client who also has a mental problem
3. Creating an awareness of the mutual problems that affect DDD workers and crisis screeners, such as lack of resources, respective lingo, job stress, and cultural issues and concerns
4. Fostering communication between the two divisions and joint ventures, such as DDD and DMH&H conferences

Ethical and Legal Issues

Familiarization with the rights of developmentally disabled clients (right to treatment and statutory mandate)

Cultural Awareness

1. Attitudes of crisis screeners toward the developmentally disabled client
2. Ability of mental health agency staff to service the developmentally disabled client
3. Similarities of and differences between developmentally disabled and mental health clients

Handouts for the pilot training program will include directories of DDD services, office addresses, and liaison staff.

GLOSSARY COMPILED BY THE RELATED SERVICES TASK FORCE

ADULT DAY PROGRAM Provides specialized training and care to persons with physical, mental, or psychological limitations. The service assists persons in the acquisition of the social, intellectual, and personal skills they need to maximize their potential for normal and independent functioning in society. The program is provided in a group setting during the day. It includes an individualized program plan; educational, developmental, and recreational activities; health, nutrition, and social service activities; a nutritious meal and snack program; help with arranging transportation; and assistance with the basic tasks of everyday living.

ADULT EDUCATION Provides a person over eighteen years of age with opportunities for acquiring knowledge and skills not included in their formal education. Teaching and learning are done in an informal but structured setting. The program is offered by many institutions and organizations, including adjunct or separate departments of schools, colleges, and universities (usually without formal admission requirements). The program includes activities that help the person to develop fundamental tools of learning, prepare for a post-secondary career or education programs, upgrade his/her occupational competencies, prepare for a new career, and develop skills in and appreciation for special interests. The service may be geared specifically toward the acquisition of a General Equivalency Diploma (GED), the successful completion of a program in Adult Basic Education (ABE), or English as a Second Language (ESL).

CASE MANAGEMENT Comprehensively organizes a client's experience in the human service system to maximize the efficiency and effectiveness of the system for that client. The scope is comprehensive in that it identifies and analyzes all of a client's problems and needs, recommends appropriate service resources, and ensures that the services are rendered to the client. It involves a systematic problem and need identification and analysis, service planning, preparation of a written service plan (developed in cooperation with and agreed to by the client and/or guardian), access to services through referral and/or appointment scheduling, follow-up activity involving client and agencies to determine actual service rendered, client satisfaction, progress, and program plan revision where appropriate.

CHORE SERVICE Provides unskilled or semi-skilled home maintenance normally done by family members, when a client is unable to perform this work and there is no other responsible person to do it. The service includes buying materials. Chore service is provided to maintain the client's health and safety in the home. Services include: cleaning (attics, walls, rugs), yard care, snow removal, moving trash to collection points, grass cutting, moving coal and ashes, non-expert pest control, and assistance with emergency shopping. Not included are major house repairs, e.g., rewiring, extensive painting, or activities specifically covered by other services, such as Homemaker Service. Service is provided according to individual needs and is specified in the written service plan.

COGNITIVE REHABILITATION Service designed to remediate disorders of perception, memory, and language in brain-injured persons.

COMMUNITY TRUST Enables parents, other family members, and friends of persons with severe chronic disabilities to pool their resources and set up a fund through a community trust. A board administers the trust. A community trust is a non-profit organization that offers the following services: (1) administration of special trust funds for persons with severe chronic disabilities, (2) follow-along services (i.e., services designed to ensure that the needs of a beneficiary are met for as long as required) that may include periodic visits to the beneficiary and the places where the beneficiary receives services and participation with service providers and/or the beneficiary in the development of individualized plans, and (3) guardians for incompetent persons with severe chronic disabilities, when no family member or friend is available, and advice for those guardians.

COORDINATED HOME HEALTH CARE Provides basic health service to selected patients who can be cared for at home. The service includes part-time, bedside nursing care under medical supervision and may also include home health aide services and extension of certain basic hospital services: occupational therapy, physical therapy, speech therapy, medical social service, and homemaker service.

DENTAL TREATMENT Provides regular dental health care and may include cleaning, tooth extraction, filling cavities, and tooth replacement with artificial materials.

EDUCATION INTERACTION Ensures that developmentally disabled persons receive the optimum educational program to develop their maximum potential, which may make it possible for these individuals to become contributing rather than dependent members of society. This service includes working with the family and/or developmentally disabled persons and advising them of their educational rights and the responsibility of the public school system for providing appropriate services and information as well as assistance with writing Individualized Education Programs (IEP), assisting local school parent groups with improving educational opportunities for developmentally disabled persons, and providing other assistance when needed in the educational process by those who are developmentally disabled.

EMERGENCY SERVICES Includes immediate access to resources meeting basic needs (housing, food, clothing, medical, personal care, etc.).

FAMILY PLANNING SERVICE Meets contraceptive needs and advises on infertility problems through educational, medical, and social services that enable individuals voluntarily to determine family size, spacing of children, and prevention or reduction of unplanned pregnancies. Services are available without regard to marital status, age, sex, or parenthood.

HOUSING MAINTENANCE SERVICES Provides repair services to maintain the safety and efficiency of a household. Services include: replacing window panes; repair of electrical plugs and cords; furniture repair; repair of stairs, floors, and walls; minor exterior repairs; painting; and plumbing. Also included is installation work needed to maintain safety and efficiency in the home and to adapt the home for disabled persons. Caulking and installation of screens, storm windows, shades, curtain rods, and handrails are included.

INFORMAL SOCIALIZATION Provides opportunities for people to meet and interact with others in various ways: dinners; conversation groups related to topics of mutual interest, needs or concerns; and participation in cultural or recreational activities. The intent is to provide satisfying social interactions and opportunities for persons to meet one another for independent relationships, such as friendships and dating.

INFORMATION AND REFERRAL, OUTREACH Information and Referral offers immediate data regarding available community resources or services in response to an expressed need, inquiry, and/or complaint. This includes any data deemed necessary to respond adequately to the request, e.g., eligibility criteria, contact person, office hours, location of service, and/or available transportation. In addition, information and referral may include, when considered appropriate, a process for transmitting client data to the identified resource or service. Outreach facilitates a client's access to available community services through a process of personal contact, needs identification, and interagency referrals. Outreach also includes a public education and relations component.

LEGAL ADVICE AND CONSULTATION Provides advice for clients on their rights and responsibilities before the law and interpretations of legal codes and processes as they relate to specific needs, issues, problems, and concerns.

LIFE SKILLS EDUCATION Provides practical education and training, in formal or informal classes, in the skills needed to perform the activities essential to daily living. Instruction may be provided in areas such as nutrition and food preparation, maintenance and care of the home, shopping, consumer-related education, management of household finances, health maintenance, and infant and child rearing.

MEDICAL INSURANCE Prepays costs of medical insurance policies covering essential medical care and services.

MEDICAL SUPPLIES AND EQUIPMENT PROVISION Obtains and distributes medical supplies and equipment (e.g., beds, feeding tables, wheelchairs, prosthetic devices, accommodative aids, eye glasses, and drugs) to eligible persons. This definition has been expanded to include rehabilitation engineering.

NETWORKING Establishes social support groups.

OCCUPATIONAL THERAPY Directs an individual's participation in selected tasks to restore, reinforce, and enhance performance; facilitate learning of those skills and functions essential for adaptation and productivity; diminish or correct pathology; and promote and maintain health. The fundamental concern is the development and life-long maintenance of the capacity to perform, with satisfaction to self and others, those tasks and roles essential to productive living and the mastery of one's self and environment.

OUTPATIENT MEDICAL CARE Provides diagnostic and speciality treatment services to individuals suffering from illness, injury or physical conditions that require skilled care best provided under hospital auspices but not requiring overnight hospitalization of the patient. Speciality clinics (e.g., clinics specializing in orthopedics, pediatrics, obstetrics, neurology, geriatrics, dietetics, physical medicine, minor surgery, and radiology) are provided, depending on the size of the hospital and the speciality qualifications of its medical staff.

PERSONAL CARE Provides basic non-medical personal care in the home, e.g., bathing, grooming, and assistance in dressing.

PHYSICAL THERAPY Provides the treatment necessary for individuals to overcome the disabilities that interfere with the activities of daily living, i.e., the physical limitations of movement and bodily functions. This treatment includes the application of a range of therapeutic modalities, including exercise, gait training, massage, heat, water, light, and electricity.

PREVENTION Includes a comprehensive set of strategies and programs designed to reduce or eliminate, to whatever extent possible, the potential causes and sources of developmental disabilities. This includes genetic counseling.

RESPIRE CARE Provides relief from caretaking responsibilities for those persons charged with this duty. It includes the provision of substitute caretakers. This service protects caretakers and their charges from the destructive effects of over-intensive or prolonged, uninterrupted caretaking responsibility.

SELF-ADVOCACY Encourages developmentally disabled persons to speak and act on their own behalf in regard to their rights, interests, and welfare.

SOCIAL RECREATION Combines opportunities for personal growth and satisfaction with opportunities for social interaction and relations through a variety of planned recreational and leisure activities in a social context. This service may include gaining access to game rooms, libraries, reading rooms, athletic equipment and gyms, swimming pools, films, lectures, and musical entertainment. It provides organizational arrangements for a variety of social activities appropriate for persons with specific social needs and interests and also provides instruction in the development of social skills.

SPECIAL PARENT AND FAMILY INSTRUCTION AND TRAINING Instructs family members in specialized techniques and appropriate expectations related to the functioning and development of a person with special conditions and needs due to physical, mental, or social limitations. This instruction involves the development of specific skills in the family to support the disabled member in ways that supplement, implement, or compensate other activities (e.g., school, work, and service). This may include centralized group or at-home individual instruction, development of informal support groups of persons in a similar situation, and provision of counseling and consultation on an as-needed basis.

SPEECH THERAPY Provides the treatment necessary to train or retrain individuals whose speech is impaired due to cerebrovascular, muscular, or congenital disability. Disorders of articulation, phonation, fluency, and symbolization are also treated.

SUPPORTIVE COUNSELING Assists clients in the personal adjustment that promotes sound personality development and social functioning in persons experiencing personal and interpersonal problems, whether pertaining to basic personality, temporary situational stress, or a disabling condition. Efforts are made to develop personal and social strengths that can help people cope more effectively with disabilities and/or life situations and their stresses. Attempts are made to change attitudes, broaden perspectives on available alternatives, increase communication skills, examine goals and values, etc.

TECHNIQUES FOR DISABLED PERSONS Instructs visually impaired and physically disabled persons in techniques needed to compensate for their disabilities. Included are techniques for performing activities of daily living, communicating with oneself or others (e.g., braille), mobility training for people who are visually impaired and physically disabled (in their own homes and in the community), and provision for special devices and training in their use.

TELEPHONE REASSURANCE Provides telephone calls at specified times (as often as necessary) to or from individuals who live alone, or who are temporarily alone, to determine if they are safe and well or if they require special assistance, and to provide psychological reassurance.

THERAPEUTIC GROUP COUNSELING Uses group processes and supports to develop in individuals the capacity to overcome specific personal problems or problem conditions. Therapy may be organized on the basis of specific conditions that characteristically produce adjustment problems (adolescence, old age and retirement, divorce, or being an ex-convict) or on the basis of specific problems or dysfunctions (diagnosed mental disorder or physical disability, alcoholism, overweight, gambling, etc.). The activities aim at the redirection of energies toward positive personal and social goals, raising levels of aspiration, reduction of maladaptive behavior patterns, change in dysfunctional attitudes and perspectives, and healthier expression and fulfillment of individual and group potential. These activities must be conducted by a professional who is trained in therapeutic techniques.

VOLUNTEER RECRUITMENT, TRAINING, AND PLACEMENT Provides a systematic process for recruiting and training volunteers to perform particular human service or administrative activities and for matching and placing volunteers in suitable assignments.